ADOLESCENT BEREAVEMENT

BY

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This study is dedicated to the memory of my parents, J. B. and Catherine C. Hodges, through whose lives I learned to believe in myself, through whose love I learned to care for others, and through whose deaths, I learned to understand grief.

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Clinical experience and a review of the literature indicate that very little is known about the experience of adolescents following the death of a loved one. Adolescents, believed to lack coping skills and an adequate support system, are predicted to have a particularly difficult grief adjustment. This study sought to describe the reactions of bereaved adolescents following the death of a parent. Due to the lack of prior research, this study aimed at developing a methodology and instrumentation for adolescent bereavement research and to establish baseline data. The study focused on a sample of bereaved adolescents whose parents had been terminally ill and had been patients of a home-based Hospice. All parents had died within two and a half years prior to the study. Thirty subjects participated in the study. They were asked to complete the

Edwards Personal Preference Schedule (EPPS) and the Youth Bereavement Questionnaire constructed by the author. The research questions consisted of comparing the sample to the normative population on the EPPS scales and looking at the variables of age, sex, relationship to the deceased, support, and length of time since the death in terms of the EPPS scales and the adolescents' grief reactions. The conclusions suggest that bereaved adolescents tend to seek attention through various behaviors. This is particularly true following the death of an opposite sex parent. Furthermore, males are more likely to cope with death through order and organization, and adolescents who lose a mother tend to be more intraceptive than those who lose a father. Neither length of time since the death nor support from others were found to be significant predictors in terms of grief reactions. A number of questions were asked of the subjects in order to describe their grief experience. In general, this group felt positively about their relationship both with their deceased parent prior to the death and with their surviving parent. This group also felt positively about the support they had received from others following the loss. The implications for clinical practice and future research were discussed.

CHAPTER I
INTRODUCTION

Research in the field of death, dying and bereavement has grown rapidly in the past few decades. However, there is a paucity of research which focuses specifically upon the distinctive problems of bereaved adolescents. There is a tremendous need for such research. The adolescent, who is already faced with many developmental tasks, usually has little experience upon which to draw in coping with the traumatic loss of a loved one. Increased understanding of the dynamics of adolescent bereavement will help psychologists, counselors, teachers, and others who are called upon to provide guidance and support for such adolescents.

The primary focus in the field of death and dying has been on adults. Foremost among writers in this field is Elisabeth Kubler-Ross. Her writings, and those of others in the field, have reported on the psychological reactions of both terminally ill people and their families. Other literature has focused on the bereavement reactions of adults, usually following the death of a spouse. Literature on children has looked at children's cognitive understanding

of death and their fears related to it. Other literature has looked at how children cope with their own dying or the death of a loved one. The topic of adolescent bereavement, however, has been largely neglected in the literature.

Adolescence is a period of development marked by a search for identity and a move from family to peers for primary support. Generally, it has been characterized as a turbulent time due to the many psychological, social and physical changes occurring during this period.

The death of a loved one is a traumatic experience for any person. Studies of bereavement have emphasized the long-term effect of such an experience and have looked at factors which contribute to its resolution. The literature has consistently shown that emotional, physical, behavioral and family problems frequently occur after the death of a family member.

When the developmental period of adolescence coincides with the death of a loved one, significant psychological effects may be expected. Adolescents frequently do not get support from adults. Rather, they are expected to be strong, capable of providing support for other family members. Their peers may not provide support due to their own anxieties about death. An additional problem is that adolescents have not fully developed mechanisms for coping with stress.

The literature reports widely varied estimates of the number of children and adolescents who are bereaved. Palombo (1981) states that 6 percent of children and adolescents under the age of 18 will lose one or both parents. Other reports vary from 4.9 percent (Berlinsky & Biller, 1982) to 20 percent (Kalish, 1985). Ewalt and Perkins (1979) did a study of 148 high school students and found that 93 percent had seen a dead person, 84 percent had had someone close to them die, 27 percent had been present when someone died, and 10 percent had had at least one parent die. In addition to parent death, children and adolescents experience the loss of grandparents, siblings and friends.

This research will specifically address the psychological reactions of bereaved adolescents. While some literature has included this group with studies on children, others seem to have assumed that adolescent grief is similar to that of adults. This group has rarely been studied as a distinct entity. The focus will be on adolescents who have lost a parent. The group will be divided according to the time lapse since the death has occurred, the sex of the parent, the marital status of the parents at the time of the death, and by age and sex of the subject. Subjects will be asked to complete a questionnaire which includes a description of their own coping, their family's coping, and problems that may have arisen following the death. They

will also complete the Edwards Personal Preference Schedule, a measure of normal personality traits, and be compared to the normative group on that instrument.

As background for this research, literature in the areas of adult bereavement, child bereavement, adolescent development, and family stress theory will be reviewed. The focus of this literature review will be to look for factors which might affect adolescent bereavement as well as theories which might serve to guide the research. The literature review will also look at dependent variables in current research. A list of the possible effects of adolescent bereavement will be developed. The limited research that has been conducted in the area of adolescent bereavement will be reviewed.

CHAPTER II
REVIEW OF THE LITERATURE

Grief and Bereavement

The terms bereavement, grief, and mourning are frequently used interchangeably. Researchers in the field, however, make certain distinctions between the terms. Bereavement refers to the experience of having suffered a loss. Mourning is the cultural response to bereavement, including the religious or ethnic rituals associated with it. Grief refers to the process of "working through" the loss which involves psychological, social, and physical reactions to it. Using these definitions, then, it can be seen that grief does not always follow bereavement (Lagrand, 1986; Rando, 1984).

Theory

A number of theories exist which attempt to explain the grief process following the death of a loved one. Rather than having major differences, however, they tend to emphasize different aspects of the grief reaction. They also lead to different conclusions regarding therapeutic techniques to deal with complicated or pathological grief.

In general, the theoretical models are based on clinical experience rather than on research data.

Psychoanalytic theory. In "Mourning and Melancholia," Freud (1957) proposed that mourning is a normal response to loss and does not usually need medical treatment. He stated that the symptoms of mourning closely resemble those of melancholia. While melancholia involves dejection, decreased ability to find interest in activities and people, and low self-regard, mourning involves all of these except the low self-regard. The work of mourning, according to Freud, consists of withdrawing of the libido from the love object, thus enabling the bereaved person to make new attachments. To do this, the bereaved person must review all thoughts and memories of the deceased. Pathological grief most often occurs when the bereaved had ambivalent feelings toward the deceased. Following the death, the aggressive feelings are then turned inward and result in depression.

Horowitz et al. (1980) propose a revised psychodynamic theory. Normal mourning occurs when "the relationship with the deceased was one in which both self and other were regarded as competent, giving, caring, and responsible" (p. 1160). Gradual acceptance occurs and the ties to the deceased are detached, but the lost attachment is always retained as a positive memory. Horowitz et al. state that pathological grief is the result of distorted self-images

and role-relationship models. Therefore, according to this theory, certain people are predisposed to pathological grief. For example, if the role relationship with the deceased person was one of dependency, the bereaved person responds to the death with intense fear and sadness.

Rosenblatt (1983) also agrees that grief work involves a review of memories, but says that it is normal for this to alternate with periods of denial. The bereaved person may avoid reminders of the deceased at times in order to direct their energy toward other tasks. Therefore, grief comes in surges, particularly around holidays and other events which trigger memories of the deceased. Gradually, the surges become less frequent. Rosenblatt states that problems occur when a person avoids all reminders of the loss and, thus, grief work is not completed.

Osterweis et al. (1984) explain that current psychoanalytic theories maintain an emphasis on intrapsychic processes, but also look at interpersonal dynamics and sociocultural factors as influencing the grief process. In particular, they emphasize the role of pre-existing personality and relationship variables. People who are psychologically healthy prior to bereavement are unlikely to develop a pathological grief reaction. It is the unstable person for whom this may occur.

Stage theory. Bowlby (1980, p. 85) was one of the first to propose a stage theory. Bowlby's theory, most

commonly called "Attachment Theory," is based on his belief that response to loss is largely instinctive. He studied the reactions of infants and animals to separation from their mothers and found much similarity between the two. He then applied this to his theory of adult grief. Bowlby states that attachment behavior is an instinctive response to seeking proximity to a preferred individual. This is a normal, healthy part of the development of an individual.

Bowlby observed that certain reactions are common in response to separation from the attachment figure. The same reactions he said occur in bereavement. These reactions, he said, occur in stages. He defined the four stages of grief as "phase of numbing . . . phase of yearning and searching . . . phase of disorganization and despair . . . phase of greater or less degree of reorganization" (Bowlby, 1980, p.85). During the period immediately following the death, the bereaved person experiences feelings of being shocked and stunned. At this stage, the person does not feel the full impact of the loss. During the second stage, the person experiences anger, restlessness, and preoccupation with thoughts of the deceased person. During phase three, the person experiences depression and anxiety. It is at this stage that they begin redefining themselves and their situation. Finally, the bereaved person begins creating a new life and forming new relationships.

According to Bowlby, pathological grief occurs when a bereaved person becomes fixated in the first stage. While the symptoms of pathological grief are similar to those of normal grief, the two vary in intensity, duration, and domination of overall functioning. Bowlby attributed pathological grief to having had a pathological relationship with the deceased. The person who had an ambivalent or overly dependent relationship with the deceased prior to the death is more likely to have problems during bereavement. Bowlby believed that the type of relationship a child develops with their first attachment figure largely influences later attachments made in adulthood. A secure attachment during infancy facilitates the development of healthy relationships later on.

Other stage theories reflect similar patterns of the normal grief response. Feifel (1983, p. 93) designates three stages of grief: "Stage I: denial, shock and disbelief . . . Stage II: despair and mental images of the deceased . . . Stage III: recovery, resolution, and return to normalcy." Frequently, the stages Kubler-Ross proposed that a dying person goes through, prior to his or her death, have been used to refer also to the grief process of bereaved persons. These stages are denial and isolation, anger, bargaining, depression, and acceptance (Rando, 1984).

Worden (1982) proposes an alternative stage theory which emphasizes an active approach to grief. He explains

that grief is a process rather than a state. He says that grief takes effort, and that there are four primary tasks of mourning. Task 1 is to accept the reality of the loss, Task 2 is to experience the pain of grief, Task 3 is to adjust to an environment in which the deceased is missing, and Task 4 is to withdraw emotional energy from the deceased and reinvest it in another relationship. He sees the whole process as taking one to two years to complete.

Hardt (1978-79) conducted a study of bereaved individuals and believes the findings support a stage theory. In his study of 692 bereaved people, 13-26 years old, he identified five stages through which they appeared to go. They were 1) denial, 2) false acceptance, 3) pseudoreorganization, 4) depression, and 5) reorganization. Hardt said that the fifth stage generally occurred around the eighth month of bereavement.

While stage theories remain important in the literature on grief and bereavement, there is now general agreement that they are not sequential as they once appeared (Lagrand, 1986; Rando, 1984). In fact, a bereaved person may experience several stages at once and experience periods of progression and regression. Full resolution of the grief process may take approximately two years (Parkes & Weiss, 1983).

Crisis theory. Gerald Caplan (1970) views the death of a loved one as a crisis in a person's life. He defines

crises as "short psychological upsets which occur from time to time as a person wrestles with life problems temporarily beyond his capacity" (p. 521). He maintains that, ordinarily, people have homeostatic mechanisms operating. This equilibrium is disrupted when a crisis occurs and a person is no longer able to function normally. A number of physical and behavioral symptoms occur during a crisis. These include restlessness, muscle tension, insomnia, decreased appetite, fatigue and feelings of anxiety, guilt, hostility, and depression. When a crisis occurs, a person rehearses various responses to it. This frequently involves invoking memories of similar crises in the past. Caplan believes crises can have positive or negative outcomes. While some people may develop mental disorders following a crisis, others grow and learn from the experience. Successful resolution of a crisis is influenced by the attitude the person has in approaching it. A person who has dealt with crises successfully in the past will approach a new crisis with confidence and optimism. Caplan says that in bereavement, the person must find ways to deal with loneliness and make new attachments.

Cognitive theory. The cognitive approach emphasizes the bereaved person's view of the situation. If a person tends to have a negative view of him- or herself and a pessimistic view of the future, such beliefs will be intensified following bereavement. They may develop a

feeling of helplessness due to their feeling of powerlessness in the face of a loved one's death (Osterweis et al., 1984).

Ramsay (1979) explains that pathological grief sometimes resembles a phobia. A person who ordinarily faces stress and anxiety by avoiding it will do the same when he or she is bereaved. As a result, stimuli which might elicit memories of the deceased are avoided and elicit anxiety. The bereaved person gradually experiences a more generalized anxiety due to a fear of losing control.

Behavioral theory. Gauthier and Marshall (1977) emphasize reinforcement in their theory of grief. They state that when a person dies, the bereaved loses a major source of positive reinforcement and must find new ways of receiving it. In addition, they receive positive reinforcement from friends and relatives for their grieving behavior. Under normal circumstances, this reinforcement is gradually withdrawn, while new activities and recovery behaviors are reinforced. Problems occur, however, when the grieving behavior continues to be reinforced. Some people will, in fact, seek out new sources of reinforcement for this behavior if it is withdrawn by their support network.

Family systems theory. The literature on grief and bereavement still primarily focuses on the bereaved individual, but recent research, which appears promising, has begun to focus on the family in which the death occurs.

Since death occurs to one member, it is thought to affect the family as a system as well as each individual. In addition, the reaction of the family system is believed to significantly affect the grief process of the individual members (Bowen, 1976; Goldberg, 1973). Bowen states that when a family experiences the death of a family member, an "emotional shock wave" may occur. The effect of the death extends throughout the extended family. Crosby and Jose (1983, pp. 79-80) state that the impact of death on a family includes "new role realignments and structures within the family; the need to establish new patterns of authority and decision-making; loss of economic security; establishing a new social support network; concern for children's and other family member's grief; . . . loss of emotional support."

The basis for research on families and grief has been in family stress theory. McCubbin and his colleagues have led the field in this area. In 1980, in the Journal of Marriage and the Family, they provided a review of family stress theory during the previous decade. They reported on Hill's ABCX model of family stress which states "A (the event and related hardships)--interacting with B (the family's crisis meeting resources)--interacting with C (the definition the family makes of the event)--produce X (the crisis)" (p. 855).

McCubbin and Patterson (1983, p.89) have expanded Hill's model and developed the double ABCX model of family

coping. They state "(a) the stressor event, hardships, and stress; (b) the family's resources for dealing with change; and (c) the definition the family makes of this situation all influence the family's vulnerability, that is, their ability to prevent the event of change from creating a crisis." They define the stressor as an event which produces change in the family system. The hardships are the demands placed on the family by the stressor. Stress results from an imbalance between demands and capabilities.

In the double ABCX model, "a" stands for the initial stressor, while "A" represents the pile-up stressors. By this, they refer to the additional stressors which occur as a result of the initial stressor. These may involve changes in family member roles or financial difficulties associated with the stressor.

With regard to resources, "b" refers to existing resources of the family, while "B" represents the new resources the family develops in response to the stressor. There are three types of resources: individual, family, and community. According to McCubbin and Patterson (1983, p. 96), "individual resources might include, for example, the ability to manage the home and to function independently, earning potential, or any of a variety of cognitive skills. Family resources include integration, cohesiveness, flexibility, organization, shared values, expressiveness, and commitment to positive health behaviors. Finally,

community-based resources might include social support networks, medical and psychological counseling services, and social policies that enhance family functioning and protect families from harm or breakdown."

The third component of the model involves family perception, in which "c" refers to the family's perception of the stressor event, and "C" refers to the family's perception of their total situation. Whether the family defines their situation as "uncontrollable" or as an "opportunity" will influence their ability to cope with it.

McCubbin and his colleagues (1985) applied the double ABCX model in looking at adolescent coping behaviors. They specifically looked at the behaviors of cigarette smoking, marijuana use, and alcohol use. They point out that peer relationships can be either resources for support or sources of demands in terms of expectations to smoke, drink, and use drugs. They point to the developmental tasks of adolescence as pile-up stressors. These involve physiological changes, increased independence, developing appropriate social roles, academic requirements, developing values, and setting goals for the future. In their study, they found family problem-solving, spiritual support, and involvement in activities to be negatively correlated with the three behaviors under study. Family problem-solving included efforts to work out problems with family members and reduce tension by talking with parents, doing things with the family, talking with a

sibling, and doing what parents requested. On the other hand, having close friend support and ventilating feelings were both positively correlated with the health risk behaviors.

Olson and his colleagues (1983) present three dimensions of family dynamics which are important in describing family functioning. These are family cohesion, adaptability, and communication.

Family cohesion is defined as "the degree to which an individual was separated from or connected to his or her family system" (p. 70). Cohesion involves emotional bonding, boundaries, coalitions, decision-making, interests, and friends. Family cohesion is seen existing along a continuum from disengaged to separated to connected to enmeshed. They propose that the two middle levels of cohesion are best for optimal family functioning.

Weber and Fournier (1985) looked at family cohesion as it affects a family's response to death of a family member. They interviewed 50 families in which a death had occurred 1 to 44 months prior to the study. They found families with high levels of cohesion were more likely to have parents decide for their children what degree of involvement they would have in the mourning rituals. When the family had a moderate degree of cohesion, the decision of the child's involvement was more likely to be jointly made by parent and child. Furthermore, they found that the children in highly

cohesive families were less likely to be included in the family mourning rituals.

Family adaptability is defined as the "extent to which the family system was flexible and able to change" (Olson et al., 1983, p. 70). This includes the ability to change its power structure, roles, and rules in response to stress. The continuum of adaptability ranges from rigid to structured to flexible to chaotic. Again, the middle two levels are considered optimal.

Family communication is seen as facilitating family functioning. This involves the ability of family members to share feelings, needs, thoughts, and preferences. Communication can be characterized as open or closed, direct or indirect, congruent or incongruent, and validating or disqualifying. Communication skills facilitate the balance of the other two dimensions. Olson et al. (1983) propose that a family's ability to deal with stress depends on its ability to change its levels of cohesion and adaptability as needed.

Many family theorists emphasize the importance of the roles assumed by the deceased, prior to his or her death, in determining how the family will adjust to the death. According to Vess et al. (1985-6), the difficulty of reallocating the roles held by the deceased depends on both the number and the type of roles he/she performed. In addition, they state that the way the family assigns the

roles is of particular importance. If a family communicates openly, and roles are assigned on the basis of family member interest and ability, the family will reallocate the roles better than if the family rigidly assigns roles and prohibits communication.

The type of roles played by the deceased will affect family readjustment. According to Goldberg (1973), there are two primary types of roles held by family members. Instrumental roles include financial support of the family, socialization of the children, and maintenance of physical needs. Socioemotional roles deal with the giving and receiving of love and nurturance. If the deceased held the family together emotionally or was the only source of power and authority, the family experiences difficulty readjusting. On the other hand, a family in which both parents shared these responsibilities will adjust more readily. Cohen et al. (1977) found that when the mother dies, since she is usually the expressive leader of the family and serves the role of integrating the family, the family displays significantly lower communication than a family in which the father dies. A family who loses a father is more likely to be affected by the loss of his role as primary wage earner. A child, on the other hand, has expressive roles rather than functional ones. Hence, a child's death typically requires that these expressive roles be reallocated (Vollman et al., 1980).

Sometimes the role held by a family member is a dysfunctional one. If the family member was a family scapegoat, family functioning may deteriorate following his or her death if the role is not reassigned. On the other hand, if the family member only produced tension, for example, an alcoholic, family functioning may actually improve following the death.

Based on the theories presented, there are certain characteristics which are considered to constitute healthy family functioning. Most frequently mentioned is open communication of feelings and thoughts, requiring clear family structure and authority (Rando, 1984). The healthy family respects the independence of family members and includes children in decision making as is appropriate for their age. While supporting the increased autonomy of its children, it provides the emotional support they still need (Fuhrmann, 1986). A healthy family also displays flexibility in its ability to deal with change. With regard to death, this involves the reallocation of roles (Bowen, 1976; Fuhrmann, 1986; Goldberg, 1973; Vollman et al. 1980).

The healthy family, when confronted with the death of a family member, has a period of adjustment and change, but is more likely to progress through the grief process positively than is the case in a dysfunctional family. Vollman et al. (1980, p. 100) in their study of bereaved families found that, in response to death, "the degree to which it is

permissible to express feelings of sadness and loss, as well as the less acceptable reactions of anger, guilt, and relief, seems to play a large role in determining the success of the readjustment period." Bowen (1976) points out that initially, a healthy family may show greater reaction to the death of a family member because the dysfunctional family is more likely to deny its feelings about it. The healthy family, however, will readjust more quickly than the dysfunctional family, who may display physical or emotional illness, or social misbehavior in one or more of its members.

Dysfunctional families may include the following characteristics: restricted communication patterns, enmeshed boundaries, inflexible rules, unbalanced power, inflexibility to change, and inappropriate amounts of support--too much or too little (Fuhrmann, 1986). An unhealthy family may cope with the death of a family member by trying to replace that member, e.g., a parent may remarry after the death of a spouse, parents of a child who died may have another child, or surviving siblings of a child who died may be expected to fill the parent's expectations for the deceased child. While remarriage or having another child are not dysfunctional in and of themselves, they can have serious consequences for the family if they are used for avoiding the grief process(Goldberg, 1973; Rando, 1984).

Factors

Anticipatory grief. Preparation for the death has been found by the majority of researchers to significantly influence the grief process. An unexpected death has been found to be associated with poor resolution of grief more often than is the expected death of a loved one (Glick et al., 1974; Lagrand, 1986). However, the theories about why this is so, vary. Some theorize that it is because much of the grief process actually occurs prior to the death. According to this theory, the length of the grief process is the same, but starts at different times. The stage of shock, for instance, would occur at the time of hearing of the prognosis, rather than at the time of death (Aleksandrowicz, 1978; Kalish, 1985). Glick et al. (1974) however, state that the grief process is different when it is expected as opposed to when it is not expected. When death is expected, family members rehearse the event in their minds many times. When the death finally occurs, there is less shock. The bereaved person is less likely to feel out-of-control. When unprepared, the person may experience chronic apprehension and feel insecure. They are more reluctant to enter into new relationships for fear of experiencing another unexpected death. Rando (1984) adds that the shock of an unanticipated death depletes a person's coping resources which affects the ability to deal with grief.

Though the consensus is that those who are prepared for the death fare better in bereavement than those who are unprepared, researchers also generally agree that there is an optimal period of preparation. They point out that when the illness of a terminally ill family member is long and drawn-out, the family's coping resources are diminished and bereavement outcome is poorer. They are emotionally exhausted. They may experience social isolation due to having spent so much time caring for the patient. In addition, the family members frequently begin to wish for the death to occur and then feel guilty for having had such thoughts. Finally, while the period of the terminal illness may enable family members to become closer and resolve unfinished business, it may also result in distancing of family members from the patient in preparation for the death (Kalish, 1985; Rando, 1984).

Parkes (1975) studied 68 widows and widowers under 45 years old. He interviewed them at three weeks, six weeks, 13 months and then at 2-4 years after their spouses' deaths. He found little or no prior warning of the death was related to greater impact immediately following the death and more lasting disorganization. Sanders (1979-80), on the other hand, found no difference between sudden death and chronic illness on the spouses' bereavement reactions in the group she studied.

Relationship characteristics. The quality of the relationship between the deceased and the bereaved prior to the death appears to be an important factor in determining the course of bereavement. Glick et al. (1974) found, in their study, that widows experienced more distress when they had regrets about problems in their relationship with their spouse. Many researchers state that if the relationship involved feelings of ambivalence or dependency, resolution of grief will be more difficult (Aleksandrowicz, 1978; Fulton, et al., 1982; Kalish, 1985; Lagrand, 1986; Rando, 1984).

Parkes (1975) found those reporting a high level of ambivalence in their relationships with their spouses prior to bereavement were similar to the low ambivalence group at three weeks after the death. However, at 13 months, and again at the 2-4 year follow-up, the high ambivalence group showed significantly more disturbance, including depression, guilt, anxiety, social withdrawal, and worse physical health. Spouses reporting an insecure or clinging relationship with their spouses also showed poorer outcome. Those few spouses who reported having openly hostile relationships with their spouses, however, had good bereavement outcomes.

Sex. Men and women have been found to grieve differently by several researchers (Glick et al., 1974; Lagrand, 1986; Rando, 1984). These studies have focused on

people who have lost a spouse. Glick et al. state that both men and women experience painful grief feelings, but that they express them much differently. They found that while women report feeling abandoned, men are more likely to feel they have lost a part of themselves. Men are unable or unwilling to express their grief feelings. They believe it is important to display self-control. They are less likely to talk to friends and family about their feelings. Men are likely to approach the loss in a realistic manner. They less often voice feelings of unfairness about the situation. Their concern is with reestablishing a normal lifestyle, caring for children and home. Therefore, men are found to remarry quicker than women. Lagrand (1986) had similar findings. He adds that men tend to avoid reminders of the deceased. Men are more likely to cope with the loss with a problem-solving approach, while women emphasize the importance of expression of feelings. Women display more intense emotions for a longer period of time. They are also more likely to display physical reactions such as headaches, nausea, and exhaustion. Sanders (1979-80) also found differences in widows' and widowers' bereavement reactions. She found widows displayed more overt reactions including more somatic problems, while the widowers scored higher on denial. Though the differences in expression of grief between men and women are well documented, the researchers

do not believe that one or the other experience poorer outcome.

Individual factors. Characteristics of the bereaved person seem important in determining the grief process. Bowlby (1980) states that the personality of the bereaved person is the most important determinant of bereavement outcome. In particular, he notes the person's typical style of coping with stress is important. For example, if a person fears losing control or appearing weak by displaying emotions, he or she may have greater difficulty in resolving his or her grief. Coping mechanisms can either help or hinder the grief process. Other personality factors that may be important include self-esteem, values, needs and strengths. Research on the effect of age of the bereaved person is inconclusive. Researchers studying the loss of a spouse, however, generally report that younger widows and widowers experience more difficult adjustment to grief (Glick et al., 1974). Rando (1984) reports that maturity and intelligence of the bereaved person are positively correlated with coping skills and positive bereavement outcome.

Death surround. The type of death and other circumstances surrounding it are important factors in affecting grief (Kalish, 1985; Raphael, 1983). Most state that the suicide of a family member is one of the most difficult types of death with which to cope. They attribute

this to the stigma, lack of support, and feelings of guilt for not having prevented it. In addition, the bereaved person may feel rejected by the deceased, leading to decreased self-esteem (Bowlby, 1980; Raphael, 1983). Other difficult losses include homicide, and deaths where the body cannot be recovered (e.g., in war) (Bowlby, 1980; Kalish, 1985). How the person is told of the death and the appearance of the body when last seen may also affect bereavement. The bereaved person's perceptions of the preventability of the death are another important factor. Though researchers generally believe the rituals associated with the death can help or hinder the grief process, there has been little investigation into the specifics of this aspect of the process (Bowlby, 1980; Kalish, 1985).

Prior grief experience. Prior experiences with death are believed to influence the grief process (Rando, 1984). If a prior loss has been dealt with positively, then subsequent losses will be easier to resolve. The bereaved will be more optimistic about their ability to cope with the loss. However, if there were problems with the prior experience, and the grief is unresolved, this will complicate the current grief process (Lagrand, 1986; Kalish, 1985).

Stressors. Other stressors, whether or not they are related to the death, will influence the grief process and result in poorer bereavement outcome (Parkes, 1975; Vachon

et al., 1982). Unrelated to the death, the person may be having marital or work difficulties. Associated with the death, the bereaved may have to start working, move to a new residence, take primary care of children, or cope with altered relationships. The more stressors a person is experiencing, the slower the grief will be resolved (Kalish, 1985).

The evidence regarding the importance of socio-economic status on bereavement outcome is conflicting. Parkes (1975) found widows of husbands who had low incomes and low occupational class had poorer bereavement reactions. While Parkes found a relationship between SES and outcome at 13 months, he did not find a relationship at three or six weeks, or at the 2-4 year follow-up. Parkes notes that a number of variables are related to low SES. These include having a large number of children under the age of six, short terminal illnesses from causes other than cancer, high incidence of divorce or separation, alcoholism of the husband, and deplorable home backgrounds. Therefore, it is difficult to determine what aspect of low SES may influence bereavement outcome. Some researchers believe SES is an insignificant factor in bereavement outcome (Bowlby, 1980; Sanders, 1979-80).

Support system. The amount and nature of support received from family, friends and support groups influence the grief process, also. Support generally improves the

outcome of bereavement though it should be noted that many bereaved people withdraw from their support network at this time. They may not use the support even though it is available to them (Silverman, 1969; Silverman & Silverman, 1979; Vachon et al., 1980).

Reactions

Normal grief reactions. The literature on grief is fairly consistent in its description of typical reactions experienced by bereaved persons. The first attempt to look at grief reactions was made by Lindemann in 1944. He studied 101 bereaved persons and found that grief commonly involves "sensations of somatic distress..., a feeling of tightness in the throat, choking with shortness of breath, need for sighing, and an empty feeling in the abdomen, lack of muscular power, and an intense subjective distress described as tension and mental pain" (p. 141). The feelings that were commonly reported in his study were feelings of unreality, distance from other people, guilt, anger, restlessness, and preoccupations with thoughts of the deceased person.

There have been many studies of grief since Lindemann's initial study, but the results are virtually the same. Grief reactions have been found to generally fall into four categories: emotional, physical, social/behavioral, and cognitive.

Emotional reactions. By far the most common reactions to bereavement are the feelings of sadness and depression. In the Glick et al. (1974) study, 88% of the bereaved spouses reported sadness and despair. Immediately after the death, shock, denial, and numbness are common. Glick and his colleagues report that the feeling of shock was reported as often by widows who anticipated their husband's deaths, as by those who did not. Frequently, anger at doctors, God, or other family members is reported. Guilt about feeling responsible, in some way, for the death, or for things done in the relationship, is also common. Other common emotional reactions include anxiety, fear, helplessness, hopelessness and apathy. If the death was preceded by a long terminal illness, feelings of relief are common (Clayton, 1971; Kalish, 1985; Lagrand, 1986; Rando, 1984). This, however, may produce feelings of guilt which can complicate the grief process.

Physical reactions. The bereaved person is likely to experience problems sleeping and loss of appetite. Glick et al. (1974) found 40% of the bereaved spouses reported sleeplessness, while 36% had a loss of appetite. Shortness of breath, weakness, and lack of energy are common. The bereaved person may find he/she is overly sensitive to noise and other stimuli. In addition, the bereaved are more vulnerable to illness. Long-term studies have found the bereaved to have higher mortality rates when compared to

control groups (Clayton, 1971; Glick, et al., 1974; Kalish, 1985; Lagrand, 1986).

Behavioral reactions. The bereaved are likely to report crying, difficulty concentrating, and difficulty initiating activities. They may regress to earlier forms of behavior. Some bereaved persons frequently visit places and keep things that remind them of the deceased. Others avoid all such reminders. Being accident-prone is also common. Relationships with others may become especially troublesome. The bereaved may withdraw from family and friends and display anger and irritability when they are with them. Some bereaved persons resort to alcohol and drug abuse following a death as an attempt to numb themselves from the pain (Clayton, 1971; Kalish, 1985). In the Glick et al. (1974) study, 28% reported increased use of alcohol, and 27% said they had taken tranquilizers. In general, the widows tended to take tranquilizers, while the widowers tended to use alcohol more frequently.

Cognitive reactions. The bereaved report disbelief, confusion, and preoccupation with thoughts of the deceased as well as the death itself. The bereaved may experience delusions or hallucinations that the deceased person is present. Frequently, the bereaved try to find meaning for the death (Glick et al., 1974; Kalish, 1985). These include religious beliefs, e.g., "God needed him," or personal beliefs, e.g., "It made me a stronger person."

Pathological grief reactions. In addition to the normal grief reactions described, certain people experience pathological grief reactions. Lindemann (1944) described morbid grief reactions as involving the delay or distortion of the normal grief process. He said distorted grief reactions include "overactivity without a sense of loss . . . acquisition of symptoms belonging to the last illness of the deceased . . . medical disease . . . alteration in relationships to friends and relatives . . . furious hostility against specific persons . . . affectivity and conduct resembling schizophrenic patients . . . lasting loss of patterns of social interaction . . . agitated depression" (pp. 144-146).

As with normal grief reactions, more recent studies generally support Lindemann's findings with regard to pathological grief. Rando (1984, p. 64) states that pathological grief can be divided into three categories: "absence of a normal grief reaction, prolongation of a normal grief reaction, and distortion of a normal grief reaction." She gives examples of these as including denial of the loss or the feelings associated with it: absent, inhibited, or delayed grief; and chronic grief.

Childhood Bereavement

Due to the lack of research examining adolescent bereavement, it is important to determine what is known about bereavement in childhood. This section will discuss theories about childhood bereavement, factors which are believed to influence the course of childhood bereavement, and both short-term and long-term reactions of children who suffer a loss during childhood.

Theory

While the theories of adult grief can be applied to children, not as much has been written specifically dealing with the dynamics of childhood bereavement. Three theoretical positions, dealing specifically with children, will be discussed. The first focuses on the development of children's concepts about death. It is the belief of these theoreticians that a child's understanding of death is of primary importance in determining how a child will cope with the death of a loved one. The second position discussed focuses on how children handle stress. The third theoretical perspective discussed will be psychoanalytic. While it was discussed in detail in the section on adult theories of grief, the focus in this section will be on the child's capacity to mourn.

Developmental understanding of death. Much of the literature on childhood bereavement emphasizes the importance of the child's understanding of death. Furman

(1983, p. 243) states that "children who know what dead means, in concrete terms, prior to their bereavement, had a much better chance of understanding the death of their loved one" than did children who lacked this understanding. Berlinsky and Biller (1982, p. 127), however, found "the level of comprehension of death has not been directly related to the consequences of parental bereavement." Though their findings indicate younger children are more adversely affected by a parent's death, they are unsure of the cause of this. Understanding of death is only one possible factor in this. Other factors include lack of prior experience with death or greater need for parents at a younger age.

Those theoreticians focusing on the development of cognitive understanding about death base their theory on Piaget's general theory of cognitive development. They have developed a similar stage theory of children's understanding of death.

Nagy (1959) was one of the first to propose that children's understanding of death develops in stages. She said there are three stages in this development. The first stage, from age three to five, coincides with Piaget's preoperational stage. The child views death as gradual or temporary. Frequently, at this age, the child equates death with sleep. The second stage, from age five to eight, occurs at Piaget's concrete operational stage of

development. Children in this stage are primarily concerned with physical questions related to death. These include what caused the death and what happens after death. Though they now realize death is final, they do not recognize that it is universal and inevitable. The third stage, beginning around age nine, reflects Piaget's formal operational stage. Children in this stage have the capacity to gain a mature understanding of death.

Zeligs (1974) also takes a developmental orientation in looking at children and death. She states that children around the age of six begin to realize that the death of a loved one causes people to feel sad. The child may, at this age, begin worrying about dying or that his or her parents might die. According to Zeligs, a child knows by the age of seven that he or she will die one day.

Jackson (1965) presents a developmental look at children and death that is similar to that of Nagy. He says that even if a young child has a limited understanding of death, he does sense the loss and needs honesty and reassurance. He adds that only after age eleven or twelve is a child able to empathize with others' feelings and express his or her own feelings.

Though the developmental orientation emphasizes the similarity of development among children, Stillion and Wass (1979) state that a child's understanding of death depends on more than age. They believe life experiences with death,

religious background, intelligence, family values, and other factors influence a child's understanding of death.

Stress theory. Chandler (1982) has developed a theory of how children respond to stress. He says that stress is a state of emotional tension which arises from a traumatic event or a situation perceived by the individual as traumatic. A person's reaction to stress depends on 1) biological factors, such as level of arousal and physical stamina; 2) psychological resources, such as self-esteem and independence; 3) social support, including family and friends; 4) economic conditions; and 5) belief system, which involves the meaning and value given to the situation.

Chandler believes stress is more difficult for children to handle than it is for adults. Children have fewer resources and less reasoning capacity. Chandler says parents and other adults play an important role in helping a child deal with stress. Adults help interpret the stressful event to the child. If the adult is anxious about it, the child will react similarly. Chandler believes a child brought up in an atmosphere of parental love and acceptance will develop a sense of competency enabling the child to handle stress in a more constructive fashion.

According to Chandler, children's behaviors exist along two continua--one, from passive to active, and the other, from introverted to extroverted. He believes adjustment problems occur when a child is extreme on any of the

continua. In response to stress, children display behaviors in one of four categories. If a child is passive and introverted, he/she will become anxious and withdrawn. The passive-extroverted child will become dependent and demanding. The child who is introverted and active will be compliant but uncooperative, and the active-extroverted child will display acting-out behavior.

Psychoanalytic perspective. There has been considerable controversy among theoreticians about whether, and at what age, children are capable of mourning. The argument appears to be based on varying definitions of mourning. The psychoanalytic viewpoint is that "mourning consists of two apparently opposite mental processes--detachment, i.e., the gradual loosening of the inner ties to the dead loved one, and identification, i.e., the taking on of some aspects of the dead loved one's personality and making it a permanent part of oneself" (Furman, 1983, p. 245). Furman believes that while grief is a feeling of sorrow, mourning is the "mental work" which must occur after a loved one's death. Because of this definition of mourning, many psychoanalytic theoreticians believe that children are unable to mourn until they reach adolescence (Krueger, 1983; Miller, 1971; Wolfenstein, 1966, 1969). They say that children deny or avoid reality and, therefore, do not work through the mourning process. Wolfenstein (1966) supports this view with her observations of children

and adolescent in treatment following a parental death. She observed that few showed sadness or crying behavior. The children appeared to immerse themselves in everyday activities. There was no evidence of preoccupation with thoughts of the deceased parent.

Furman (1974, 1983) does believe that children are capable of longing for a lost parent by the end of their first year of life. She says a child's adjustment to the loss is dependent on their emotional health prior to the death, and the emotional support they receive after it occurs.

Psychoanalytic theoreticians do believe death has a profound impact on a child. In particular, because of the importance they place on the early parent-child relationship, they believe the death of a parent in childhood seriously affects emotional development (Freud, 1957). They see children's reactions to death including "unconscious and sometimes conscious denial of the reality of the parent's death; rigid screening out of all affective responses connected with the parent's death; marked increase in identification with and idealization of the dead parent; decrease in self-esteem; feelings of guilt; and persistent conscious fantasies of an ongoing relationship or reunion with the dead parent" (Miller, 1971, p. 714-715).

Wolfenstein (1966) notes that children tend to idealize their deceased parent. Any negative feelings they had

toward that parent are directed toward others in the child's environment, usually the surviving parent. Wolfenstein states that instead of decathecting the lost object, the child develops a hypercathexis towards it. She believes that when ambivalence toward the deceased parent returns, it is evidence that the child is beginning to accept reality.

Children may, according to Wolfenstein (1966, 1969), show poor behavior or decreased accomplishments following a parental death. This she attributes to the loss of narcissistic rewards and external ego and superego support from the parent. She sees these as important roles for a parent and believes a child must have these provided by a parent substitute if the surviving parent is not able to provide them. A parent substitute also enables the child to transfer the positive feelings for their lost parent to that person.

Some psychoanalytic theoreticians believe children do mourn. Robert Furman (1973) states that even though children do not display the same grief reactions as adults, this does not mean they are not mourning. He shares the psychoanalytic view that mourning involves the "decathexis of the internal representative" (p. 22) but believes a child is able to do this from about the age of four if his/her physical and emotional needs are being met. Furman says that a child who does not mourn a loss will be arrested at the stage of development when the death occurred. The child

is then unable to reinvest his/her feelings in new relationships.

Factors

While there is unanimous agreement that childhood bereavement can have a serious impact on a child, there has been little research on what factors determine whether or not a child will cope successfully with this experience. Berlinsky and Biller (1982) analyzed the literature on childhood parental death and identified factors which may influence the child's grief process. They believe characteristics of the child, the parent, and the family need investigation.

Child factors include age, sex, functioning of the child prior to the death, intelligence, personality characteristics, temperament, and cognitive development. Characteristics of the deceased parent include age, sex, attitude toward dying, and the quality of the relationship with the child. Family characteristics are prior functioning, structure, number and order of siblings, and changes necessitated by the death.

Family characteristics. Elizur and Kaffman (1983) emphasize family functioning prior to the death as an important determinant of bereavement. A family that had problems prior to the death is more likely to display pathological grief reactions. In families in which the parents had been having long-standing marital problems, the

bereaved children showed more intense and pervasive bereavement reactions following their fathers' deaths. According to Furman (1983, p. 243) "good emotional health prior to the stress is of enormous help, the best prophylactic measure." The quality of the relationship with the deceased person prior to the death is also believed to be an important factor. Feifel (1983) believes that the better the relationship was prior to the death, the better able the survivor is to grieve. Ambivalent feelings toward the deceased are more difficult for the survivor to resolve.

Berlinsky and Biller (1982) believe that the changes occurring in the family following the death may have a greater impact on the child than the death itself. These include changes in residence, income, a surviving parent's employment, parental remarriage, and family structure. Elizur and Kaffman (1983) found that while factors prior to the loss, such as the child's emotional condition or family functioning, influence the child's initial response to bereavement, the factors occurring after the loss, such as the mother's bereavement reaction, have a greater influence during the years following the death.

Many researchers have emphasized the importance of the surviving parent(s)' mourning process on the child's bereavement (Berlinsky & Biller, 1982; Elizur & Kaffman, 1983; Zeligs, 1974). Elizur and Kaffman (p. 673) state "where mothers exhibited overrestraint, withholding of

emotional expression, and inability to share with the child expressions of grief and memories of the deceased, the children showed signs of considerable emotional distress during the first months." They also found a significant relationship between the mother's difficulties with mourning and the child's pathological bereavement reactions during the second and third years following the death. Zeligs believes that such behavior in a parent causes the child to have difficulty expressing feelings and will increase the child's feelings of loneliness, anxiety, and confusion. One of the problems is that the child is needing support at a time when it is most difficult for the parent to provide it. Furman (1973) believes that a child can mourn successfully if the death is presented realistically and the child is allowed to express his or her feelings. He adds that the child's needs must continue to be met consistently and other relationships in the child's life continue.

Cain et al. (1964) reported similar conclusions when it came to a sibling death. Again, it is believed that the parent's mourning has a direct bearing on the surviving child's bereavement. For instance, they found some parents tried to substitute the surviving child for the lost child by putting unrealistic demands on the child. The parents may become overprotective of the surviving child, not allowing the child to mature and develop normally (Krell & Rabkin, 1979). Furthermore, bereaved siblings are

frequently told to be strong for their parents, thus discounting their own grief (Rosen, 1984-5).

Coleman and Coleman (1984, p. 131) identified other factors which may influence sibling bereavement. These include "the nature of the death, the age and characteristics of the child who died, the child's degree of actual involvement in the sibling's death, the child's pre-existing relationship to the dead sibling, the immediate impact of the death on the parents, the parents' handling of the initial reactions of the surviving child, the reactions of the community, the death's impact on the family structure, the availability to the child and the parents of various "substitutes," the parents enduring reactions to the child's death, major recurrent stresses on the child and his family, and the developmental level of the child."

Factors related to the death. The cause of the death and preparation for it are considered to be important factors which influence bereavement. Zeligs (1974) believes that a sudden death, caused by an accident or natural disaster, is shocking to the survivors. A death following a terminal illness, according to Zeligs, is more easily handled because of the time to prepare. A suicide is thought to be one of the most difficult types of death with which to cope because of the guilt and shame felt by the survivors (Furman, 1974; Zeligs, 1974). The way the family handles the death is also important. This includes

religious and ethnic rituals and the child's involvement in these.

Characteristics of the deceased. Many researchers believe that a parent's death is the most difficult type of death for a child. Furman (1974) believes this is because the child has invested almost all of his or her love in his/her parents. In comparing maternal and paternal bereavement, there is more literature on paternal bereavement, probably because of its higher incidence. Berlinsky and Biller (1982) did find variation in the reactions of children who lost a father as opposed to those who lost a mother. "Emotional disturbance, personality variables, sex-role and social functioning, juvenile delinquency and criminal activity, and deficits in cognitive-academic functioning have been associated with death of a father. Maternal bereavement has been related to emotional disturbances exclusively" (p. 126). Zeligs (1974) points out that differences in maternal and paternal bereavement are likely due to the different roles the parents play in the family. Zeligs also believes the sex of the child in combination with the sex of the parent is an important factor. She states that a child needs involvement with the same sex parent for appropriate sex-role modeling.

Characteristics of the child. There has been little research into the influence of characteristics of the child on the bereavement process. It is generally believed that

the younger the child, the more difficult the bereavement (Berlinsky & Biller, 1982; Furman, 1974). Berlinsky and Biller, however, point out that only two studies have looked at the bereavement reactions of adolescents. Therefore, conclusions about age should be tentative. With regard to sex differences, they found little difference between the reactions of boys and girls. Elizur and Kaffman (1983) found an interaction effect between age and sex. While neither age nor sex was found to be significantly related to the rate of pathological reactions, a significantly higher rate of pathology was found for boys, aged 3-6 years old, than for girls of the same age.

Elizur and Kaffman (1983) also found the child's personality characteristics to be important factors in his or her adjustment to bereavement. Children judged to have low self-control showed increased emotional and behavioral problems during the first 3 1/2 years following the father's death. Overly dependent children had the most problems 3 1/2 years after the death. A significant relationship was also found between a high level of motor activity and pathological bereavement reactions.

Reactions

Berlinsky and Biller (1982, p. 65) found in their review of child bereavement literature that "nearly all of the methodologically sound studies showed differences between bereaved and nonbereaved children." They argue with

the psychoanalytic theoreticians who say that children do not mourn. They found that "children do undergo a process of bereavement similar to that expressed by adults" (p. 66). "Such symptoms as overt denial of the reality of the death, anxiety, depression, anger, guilt, somatic complaints, and disturbances in eating and sleeping have been found in studies of children as well as in research on adults. . . . Other reactions observed in children have included reduced academic achievement, social withdrawal, rebellion, phobias, running away, accident proneness, and enuresis" (p. 21).

Common grief reactions. Jewett (1982) identified three stages in children's grief. The first includes shock, numbness, denial and alarm. The second includes yearning, searching, disorganization, despair, regression, and family reorganization. The third involves the integration of the loss and grief. In this stage, the child accepts the reality of the loss, his or her self-esteem is restored, and he or she is able to enjoy life and other people again.

Many researchers have investigated the reactions of children to death. Grollman (1967) states that common grief reactions in children include sorrow, anger at the deceased, hostility toward others, denial, bodily distress, guilt, anxiety, and panic. The child may also idealize the deceased person and/or take on symptoms the deceased person displayed prior to the death. Some children seek to find someone to replace the deceased person.

Cain et al. (1964) found denial to be the most common reaction of children who lost a parent. They said this reaction was sometimes observed in an absence of affect in the child. A young child may deny the reality of the event or his or her feelings about it. Jewett (1982) states that a parent's death causes a child to feel vulnerable and powerless. His or her feeling of self-esteem is likely to decrease. Jackson (1965) notes that children's grief is frequently displayed in their behavior rather than in stated feelings. They may display hostility or fear and may play dead. Berlinsky and Biller (1982) found parentally bereaved children to be submissive, dependent, introverted and less aggressive than non-bereaved children. Stillion and Wass (1979) point to physical symptoms of grief such as insomnia, lack of appetite, and nightmares. Fox (1984-5) found children display psychological, physical or behavioral reactions at holidays and anniversaries. Unlike adults, however, these reactions appear to be triggered by special days or events rather than calendar dates. Experiences of special significance included birthdays, holidays, and activities they had shared with the deceased.

Van Eerdewegh et al. (1982) studied 105 bereaved children, 2-17 years old. They had experienced the death of a parent 1 to 13 months prior to the study. The study involved interviewing the surviving parents regarding their children's bereavement reactions. The researchers found a

significant increase in dysphoric mood characterized by sadness, crying or irritability. This was found to decrease throughout the first year of bereavement. Other symptoms which increased following bereavement, but did not decrease during the year, included sleep disturbances, decreased appetite, withdrawn behavior, and temper. They also found significant impairment in school performance. They did not find increases in behavior problems, severe depression or psychopathology.

Reactions to sibling death. Only a few studies have looked at the reactions of children to a sibling's death. Cain et al. (1964) found that half of the bereaved siblings they studied had strong feelings of guilt lasting for years after the death. The guilt feelings were often connected to feelings that they should have died, too, or instead of the bereaved child. Young children may feel guilty due to the belief that wishing a person would die could have caused it (Furman, 1974). Other reactions they found included "depressive withdrawal, accident-prone behavior, punishment seeking, constant provocative testing, exhibitionistic use of guilt and grief, massive projection of superego accusations and many forms of acting out" (Cain et al, 1964, p. 743). They also found the bereaved siblings to be confused about illness or death, or the connection between the two. They were more likely to fear doctors and hospitals, as well. Many were found to be fearful of death

which seemed to be made worse by the parent's new overprotectiveness. Some displayed the same symptoms the deceased had shown prior to the death. Most were confused about God due to the conflict in being taught of His benevolence while at the same time being told God "took" the deceased sibling.

In an extensive study of 159 individuals who had lost a sibling during childhood, Rosen (1984-5) found feelings of guilt, sadness, loneliness, fear, anger, and numbness were common. She states that 50% report having guilt feelings related to the death. Rosen looked at the family's response to the death, and reports that only a quarter of the bereaved siblings said that they had talked with other members of their families about their grief. About a third reported feeling responsible for comforting their parents or "making up to the parents for the loss" (p. 313). One third also report their parents having long-term grief reactions.

In a review of the literature, Koch-Hattem (1986, p. 107) found that siblings of pediatric cancer patients experience "resentment, anger, anxiety, depression, fear of the patient's death, fear of their own death, jealousy of the patient, wishes that the patient would die, guilt, emotional and physical isolation from their parents, and psychosomatic symptoms and behavior disorders apparently aimed at obtaining parental attention."

Berlinsky and Biller (1982) note that bereavement may have positive outcomes, but these have not been investigated. The child may feel increased energy or motivation. Jewett (1982) says the child may feel that he or she has grown from the experience.

Pathological grief reactions. Pathological grief varies in intensity and duration, rather than in types of symptoms, from normal grief. Grollman (1967, p. 21) states that a distorted grief reaction is one that continues for an abnormally long time, such as "a continued denial of reality even many months after the funeral, or a prolonged bodily distress, a persistent panic, an extended guilt, an unceasing idealization, or an unceasing hostile reaction to the deceased and to others."

Elizur and Kaffman's (1983) study of 25 kibbutz children whose fathers had died involved collecting data at 6, 18, and 42 months following the death. They found 70% of the children had increased emotional and behavioral problems at some time during the study. About half of the children had severe and persistent problems which impaired functioning at some time during the study and were considered to be displaying "pathological bereavement." Their symptoms included "regressive overdependent behavior, manifold fears, separation anxiety, night sleep disorders, discipline problems, restlessness, learning difficulties,

eating disorders, enuresis, aggressive or inhibited behavior, and social withdrawal" (p. 668).

Long-term impact. Much of the literature on childhood bereavement has looked at its long-term impact on the child's development and adult adjustment. The results have been conflicting, however. Berlinsky and Biller (1982, p. 1) state "there is an assumption among mental health practitioners as well as the general public that experiencing the death of a parent during childhood inevitably influences an individual's future adjustment and development, and that the effects are negative. Attempts have been made to test this assumption, but the validity of research efforts is in question." The conflicting findings are due largely to problems in methodology of the studies. Tennant et al. (1981), Lonetto (1980), and Berlinsky and Biller (1982) have all strongly criticized the methodology used in these studies. Crook and Elliot (1980, p. 258) reviewed 20 studies and state "studies that have demonstrated a higher incidence of childhood bereavement among depressed patients than among non-depressed subjects have, without question, been methodologically flawed."

A number of problems have been identified in the methodology of the long-term impact studies. Most of the studies have been retrospective. The studies compare two groups of people, one group who experienced the death of a parent while they were children, and the other who did not

experience such a loss. In general, the studies have looked at groups of psychiatric patients to determine if their rate of early parental bereavement is different from that of a control group. There are several limitations to this method of study. First, the findings are correlational and, therefore, cannot prove a causal relationship between parental bereavement and psychiatric diagnosis. Second, the studies do not account for other differences between the groups which may have occurred prior or subsequent to the loss. Such factors as the subject's age, sex, socio-economic status and the deceased parent's age and sex should be taken into account. In addition, experiences following the death, such as the surviving parent's adjustment and remarriage, should be investigated regarding their impact on the child's adjustment. A third limitation of these studies is that the diagnostic criteria used vary from study to study. For example, the criteria for depression vary greatly. The control groups also differ markedly. Some studies compare bereaved psychiatric patients to non-bereaved psychiatric patients, while other studies have used patients from general practitioner's offices. A few studies have used samples from the general population, but these have been infrequent. The use of the other groups is questionable because of the possibility that other variables are intervening. Finally, the study of psychiatric patients has limited generalizability to the general population.

Obviously, the majority of children and adolescents do not develop psychiatric illnesses. There is a great need for studies of this population to determine their adjustment to parental loss. Taking these limitations into account, the findings of a number of long-term impact studies will be discussed.

Many researchers believe that childhood bereavement has a significant impact on later adjustment. Dennehy (1966) conducted interviews of 1020 psychiatric patients of various diagnoses. She found depression to be linked to parental death during childhood. The following relationships were found to be significant: mother loss in male depressives, mother loss in female depressives, father loss in female depressives, and parental loss between the ages of 10 and 15 among both male and female depressives. With regard to schizophrenia, she found a significant relationship between the death of a mother before age five and schizophrenia in both males and females. The male schizophrenics also showed an excess of father loss between the ages of 5 and 10. Male alcoholics showed an excess of parental loss, while female alcoholics only showed an excess of mother loss.

Birtchnell has conducted many studies on the long-term impact of parental death. In 1970(b), he compared a group of 482 psychiatric patients to a control group of 476. He found the incidence of parental death to be similar in the two groups. However, when he looked specifically at parent

loss between the ages of 0-9, he found a significant difference between the psychiatric patients and the control group. While over 17% of the patients had experienced a parental death during this age period, only 11% of the controls had experienced such a loss. Within that group, the greatest difference occurred when the parental death occurred between the ages of 0 and 4.

In Birtchnell's 1975 study, he examined the MMPI scores of 576 psychiatric patients. He found only one scale, Dependency, to be related to early parent death and this was only significant for women whose mothers died before they were 10 years old.

In another study, Birtchnell (1970a) studied 500 psychiatric patients. He compared those diagnosed as depressed with the non-depressed psychiatric patients. He found no difference in parental death between the two groups. However, when he looked at the severity of depression, he did find a significant relationship. He found the incidence of early maternal death to be significantly higher in severely depressed patients as compared to moderately depressed patients.

In 1972, Birtchnell compared 6795 psychiatric patients with a control group of 3425. He found early bereavement not to be a significant factor with regard to neurotics or psychotics, but did find a significant relationship with depression and alcoholism. Early bereavement appeared to be

a factor for only the female patients, and parental death between the ages of 0-9 was most significant.

Many studies have looked specifically at the relationship between parental death and adult depression. Hill and Price (1967) compared depressed patients with other psychiatric patients. They found that the depressed patients had lost more fathers between the ages of 0 and 14. The greatest differences were for female patients and for those who experienced the death between the ages of 10 and 14. No difference was found related to maternal bereavement.

Brown et al. (1977) found a significant relationship between the death of a mother before the age of 11, and depression among women. The past lost of a father or sibling before the age of 17, the loss of a mother between the ages of 11 and 17, and the loss of a child or husband were not found to be related to depression. All types of past lost, however, were associated with psychotic-like and neurotic-like depressive symptoms.

Some studies have looked more specifically at the relationship between early parental death and suicide or suicide attempt in adulthood. Birtchnell (1970c) found significantly more of the attempted suicide patients he studied had experienced a parental death, primarily between the ages of 10 and 19. Lester and Beck (1970) studied 246 attempted suicide patients. They found that among the

female suicide attempters, the experience of a recent loss as a precipitating factor was associated with the loss of both parents before age ten. No such relationship was found among the male suicide attempters. Hill (1969) studied 1483 depressed inpatients and found suicide attempt to be significantly more common in depressed women who lost their fathers between the ages of 10 and 14, and though less, between the ages of 15 and 19. Both men and women who experienced the death of a mother before the age of ten also attempted suicide more. Adam et al. (1982) compared 98 people who had attempted suicide to a group of 102 controls matched on age and sex. Parental loss was significantly more common in the attempted suicides than in the control group. This was especially true of father death or the divorce or separation of the parents between the ages of 0-5 and 17-20.

A few studies have examined the impact of early parent death on subjects from the general population. Barnes and Prosen (1985) administered a depression scale to 1250 patients from general practitioners offices. They found a significant relationship between father loss between the ages of 0-6 and 10-15 and depression. No effect was found for mother loss.

Dietrich (1984) studied 96 "normal" young adults, composed of 32 who experienced a parent death before the age of seven, 32 who had experienced a parent death between the

ages of 12 and 18, and 32 who had not experienced a parental death. They found 50% of the bereaved individuals to score as pathologically abnormal on two or more MMPI scales, compared to only 28% of the control sample. The child's sex was found to be significant, while the age at the time of death was not significant. While an early parent death appears to affect males, a later parental death had a greater influence on the females.

Bendiksen and Fulton (1975) studied 255 adult subjects. While they found more major illness and extreme emotional distress among those from bereaved or divorced childhood families, they did not find differences related to divorce rates, arrest conviction, or other indicators of behavior disorders.

Parish and Copeland (1980) studied locus of control as it relates to parental bereavement. They studied 227 undergraduate students. They found no difference on locus of control with regard to intact versus father absent homes or the sex of the individual. However, they did find an interaction effect. Males from families where the father had died showed significantly higher external locus of control than males from intact families, males from divorced families, or females whose father had died.

Birtchnell and Kennard (1982) examined the child-rearing practices of early mother-bereaved women. They looked at both psychiatric patients and "normal" controls.

The early bereaved women had more difficulties with child rearing than did the controls.

Only a few studies have looked at the impact of parental death on later childhood or adolescent adjustment. Seligman et al. (1974) studied adolescents referred for psychiatric services. Among 85 adolescents referred for treatment, they found 36.4% had experienced earlier parental death, while only 11.6% of a school sample had experienced such a loss.

Shephard and Barraclough (1976) looked specifically at children who experience the suicide of a parent between the ages of 2 and 17. They were interviewed 5 to 7 years after the suicide and compared to a control group of 150. In comparing the two groups, they found a significant difference in psychological problems reported. It is important to note that the home life of these children had been abnormal prior to the death because of the mental problems of the parent and family instability, and this prior stress was related to later functioning.

Caplan and Douglas (1969) examined the histories of 256 children referred for psychiatric services. They compared the depressed children to those who were not depressed and found a significant difference in the rate of parental deprivation before the age of eight. The deprivation included, but was not exclusive to, parental death.

Hetherington (1972) compared adolescent girls from intact homes with girls from father absent homes due to divorce, and father absent homes due to death. While she found little difference between the groups with regard to sex-role typing, she did find differences in their interactions with males. Both girls from divorced and bereaved homes showed disruptions in their interactions with males. The girls from divorced home displayed proximity and attention seeking behavior with males, while the bereaved daughters showed inhibition, rigidity, and avoidance around males. Hetherington found separation before the age of five had the greatest effect on later adolescent behavior.

Felner et al. (1975) studied large groups of young children, 5-10 years old, determined to be having significant adjustment problems. The children were studied in terms of whether they were from intact, divorced, or bereaved homes. The divorced and bereaved groups displayed significantly higher overall maladjustment scores. In comparing the two groups, the researchers found the bereaved children were more anxious, depressed and withdrawn, while the children from divorced homes displayed more aggressive and acting-out behavior.

Several studies have found no relationship between early parental death and later psychiatric illness. Ragan and McGlashan (1986) interviewed 72 psychiatric patients who had lost a parent during childhood. These patients were

interviewed 15 years after being discharged from the hospital. The authors failed to find a relationship between parental death and psychiatric illness. Crook and Raskin (1973) compared 115 depressed inpatients who had attempted suicide with 115 non-suicidal depressed patients and 285 normal subjects. While parental loss from divorce, desertion or separation was significantly higher among the suicidal group, no difference was found related to parental death. Roy (1983) found no relationship between parental death and depression when comparing a group of neurotic depressives with a control group. Hainline and Feig (1978) studied 24 subjects from father absent families and compared those for whom the loss occurred before the age of five, and those for whom the loss occurred when they were 5 to 11 years old. The father absence could be due to divorce or death. These subjects were compared with a control group from intact homes. The father-absent group showed little difference from the control group on such personality measures as sex-role typing, attitudes toward romantic-love, sex-role traditionalism, manifest anxiety, or locus of control.

The results from the many long-term impact studies are conflicting. While some show significant findings, others do not. Of the positive findings, there is little consistency with regard to age or sex of the bereaved, sex of the deceased, or later adjustment problem. It is

unlikely that parent death, alone, is a cause of adult psychological disturbance. Many variables are involved. It is important to look at the bereaved population and examine the variables which may cause some to be more vulnerable than others to the loss. These include demographic variables, as well as variables related to family adjustment, personality characteristics, and experiences following the death.

Adolescent Bereavement

While the areas of adult and child bereavement have been extensively studied, adolescent bereavement has received little notice. Berlinsky and Biller (1982) reviewed the literature on parental death and found only fourteen studies which gave any consideration to the age of the child at the time of the parent's death. Of these, only two studied adolescents and both of these were retrospective studies of adults who had lost a parent during adolescence. They conclude that "In view of the body of theoretical literature related to age-specific affective needs of children in their relationships with parents, the failure to account for age at the time of the parent's death . . . is particularly surprising" (p 8). Fleming and Adoph (1986, p 97), in their chapter on adolescent bereavement, state "There is a paucity of research investigating bereavement at this stage of development; and, on a larger scale, no comprehensive model exists to facilitate an understanding of

the adolescent grief experience." The lack of research, however, is not consistent with the impact death has on adolescents. In Ewalt and Perkins' (1979) study of high school juniors and seniors, they found 90 percent had either seen a dead person and/or had lost a relative or other person close to them. Forty percent reported having had a friend their age die, and 10 percent had experienced the death of a parent.

Corr and McNeil (1986), who edited the only book which looks specifically at adolescence and death, state that adolescents are neither adults nor children and, therefore, need to be studied independently. While developmental psychologists have said that adolescents have a concept of death that is more similar to that of adults than of children, adolescents are often treated more like children than adults when a family member dies. They may be sheltered from the death and adults frequently minimize their grief feelings. It is common for an adolescent, whose parent has died recently, to be told to "be strong" for the surviving parent.

Theory

Adolescent development. In order to understand how the adolescent copes with death, it is important to first get a better understanding of adolescence and the characteristics of a "normal adolescent." There is much literature on the period of adolescence. The way it is characterized,

however, has been varied. Until recently, the consensus was that adolescence is normally a period of turmoil and anxiety. Recent research, however, has conflicted with this view of adolescence (Fuhrmann, 1986; Stott, 1974). The new conclusion is that "stress and anxiety are no more a part of normal adolescence than at any other stage of development" (Fuhrmann, 1986, pp. 5-6). The most widely noted study in this regard was conducted by Offer and his colleagues (1981). They studied hundreds of adolescent boys and found that "normal adolescents reported no intense emotional discomfort, did not dislike their parents or their values, and did not feel rebellious against society" (Fuhrmann, 1986, p. 6).

In Offer and Offer's (1975) study of normal adolescent boys, they found them to fall into three main categories. They defined the first as continuous growth in which 23% of the adolescent population they studied fell. They described them as "purposeful, self-assured, aware of their feelings, able to cope with trauma, and able to integrate and use experience to further their own growth" (Fuhrmann, 1986, p. 22). They found these adolescents came from stable families which encouraged independence, respect, trust and affection. They had good relationships with both peers and adults. Thirty-three percent of the adolescents Offer studied fell into the surgent growth group. They described these adolescents as having developmental spurts. They saw

their self-esteem and coping skills as varying. They developed skills somewhat later than the continuous growth group. While they were generally well adjusted, they were less likely to express their feelings. Finally, 20 percent of the adolescents were characterized as having tumultuous growth. They had "considerable inner turmoil, behavioral problems, consistent self-doubts, parental conflict, . . . psychological pain . . . strong but conflicted family ties, were unsuccessful academically, and had not developed good communication skills" (Fuhrmann, 1986, p. 22). The remaining 24 percent displayed a combination of continuous and surgent growth patterns.

Norman and Harris (1981) also studied normal adolescents, and their findings support those of Offer. They surveyed 160,000 teenagers and found that 70 percent "like themselves and the single most common fear reported was the possibility of losing their parents" (Fuhrmann, 1986, p. 29). While the methodology employed by both Offer and Norman has been criticized, the large numbers of youth they studied make them significant contributions to the field of adolescent development.

In addition to the conflicting descriptions of adolescence, there is even dispute about the definition of adolescence. Studies of adolescents vary greatly in the ages they include. Fuhrmann (1986) defined adolescence as beginning with puberty, which varies from about age 10 or 11

in girls to 12 or 13 in boys, to the time when the adolescent assumes full adult responsibilities, which varies from age 18 to the late 20s. Most often, studies of adolescents have been conducted using middle and high school students.

Much of the theoretical literature on children and death, as has been noted, has been developmental in nature. When this developmental perspective is applied to the adolescent and death, the issues most frequently noted are the adolescent's growing independence and increasing reliance on peers instead of parents (Fuhrmann, 1986). Adolescence is seen as a period of much change--physical, emotional, and social. The adolescent is confronted with increasing freedom and responsibilities. Zeligs (1974) believes that adolescents are particularly vulnerable to a death experience because they already must deal with many anxiety provoking problems. Jackson (1965) also supports this view by saying that it is difficult for the adolescent to separate his/her feelings related to the particular situation from the general emotional problems of adolescence. Jackson believes the adolescent seeks to find psychological, spiritual or religious meaning for death as part of his/her on-going search for the meaning in life.

Zeligs (1974) looks at adolescent development by dividing adolescence into three separate stages: early, middle and late adolescence. In early adolescence, which she

states is approximately ages 10-14, there is great change. She sees the young adolescent as particularly concerned with his/her identity and self-image. Though the early adolescent is feeling he/she must strive for independence, he/she is not ready for complete independence. He/she begins shifting from family to peers for emotional support. Zeligs states that the parent-child relationship is not necessarily conflicting at this age, but, rather, that the relationship is built on earlier communication and understanding. If the relationship has been good in the past, it will continue to be so.

Mid-adolescence, the period Zeligs (1974) describes as being from approximately 14 to 16 years of age, is characterized by increased self-identity. This adolescent is less likely to accept peer thought and actions without thinking through them and making his/her own decision. The mid-adolescent is better able to reach out to others and give support and understanding. He or she is also more likely to accept support from others without feeling weak by doing so.

Ages 17 to 20 comprise older adolescence or young adulthood according to Zeligs. The person in this period is more mature and is taking on adult responsibilities.

Gordon (1986) divides adolescence into somewhat different periods. She sees adolescence as being from 12 to 19 years of age. She says the 12 to 15 year old period that

involves "the acquisition of formal logical thought, the onset of biological sexuality, the growth of the physical structure, and a myriad of psychological tasks," which include "entrance into a mixed gender peer group, experimenting with adult behavior and rules, and expanding geographically the territory available for experience" (p. 18). The period from 16 to 19 years of age involves "completion of physical maturation, increasing intimacy with the opposite sex, continued acquisition of adult social skills, clarification of ethics and values, further expansion of territory, and the ability to make long-term commitments to persons and goals" (p. 18).

While the cognitive development of the child has been studied widely in its relation to the child's developing concept of death, little consideration has been given to adolescent cognitive development as it relates to the death concept. Piaget saw adolescence as being the period when thought shifts from concrete-operational to formal-operational. The adolescent is able to consider potentialities and hypotheses. In addition, he/she is able to abstract. In the cognitive-social development area, growth is seen as moving from surface, in which there is a focus on people's appearance and behavior, to greater depth, in which the focus is on people's inner thoughts and feelings. The adolescent is now capable of sensitivity and empathy toward others. He/she is better able to consider

the motives and intentions of others (Flavell, 1977; Stott, 1974). Piaget believed that the acquisition of formal-operational thought makes it possible for the adolescent to think about the finality of death (Gordon, 1986).

With regard to death, Zeligs (1974) states that adolescents view death as "fearsome yet fascinating"(p.26) She says most adolescents deny their anxiety about death. Adolescents view death as being very distant (Zeligs, 1974; Gordon, 1986). Adolescents' concept of death is frequently influenced by the way they see it portrayed on television and in the movies. They see death as "excessively violent, macabre, distant, or unnaturally beautiful" (Gordon, 1986, p. 22).

Psychoanalytic theory. Psychoanalytic theorists have had much to say about the development of the ability to mourn. Many have stated the belief that a child is unable to mourn (Krueger, 1983; Miller, 1971; Wolfenstein, 1966, 1969). Furthermore, psychoanalytic theory views adolescent development as a mourning process, in itself since it is viewed as the period in which the adolescent must separate him- or herself from his/her parents in order to proceed normally into adulthood (Laufer, 1966; Sugar, 1968). Laufer (1966, p. 290) states "the detachment from the oedipal object is a normal developmental task in adolescence, which may be greatly complicated by the actual loss of the object." One complication may be in the form of

idealization of the deceased. Laufer believes that the loss of a parent, however, does not necessarily lead to pathology. He states that the effects of such a loss are determined by "the level of drive development, the quality of the object relationship, and the degree of ego maturity attained before the event" (p. 290). When mourning is successfully completed, according to Laufer, the individual is able to become interested in the world and other people again.

Adolescent grief theory. Fleming and Adoph (1986) propose a theory of adolescent bereavement which looks at the tasks and conflicts involved in normal adolescent development in relation to the grief reaction. They divided adolescence, which they define as ages 11-21, into three phases. A task and a conflict are identified for each phase. They have identified "five core issues around which bereaved adolescents attempt to accomplish some resolution of the ambivalence engendered by phase conflicts" (p. 104). The five core issues are "predictability of events; self-image; belonging; fairness/justice; and mastery/control" (p. 104). Then, cognitive, behavioral and affective responses are described in relation to each phase.

Phase I, from 11 to 14 years old, involves the task of emotional separation from parents with the conflict being between separation and reunion. Phase II, ages 14 to 17, involves the task of competency, mastery, and control, with

the conflict between independence and dependence. Finally, Phase III, ages 17 to 21, involves the task of intimacy versus commitment, with the conflict between closeness and distance.

Fleming and Adoph use the example of self-image as a core issue. In Phase I, the cognitive response involves the adolescent's realization of being unique. Despite their desire to be similar to their peers, their bereaved status makes them different. In Phase II, the cognitive response is one of being able to do anything. Having lost a loved one, however, confronts them with the reality that they cannot control the world and the events occurring in their lives. In Phase III, the cognitive response involves wanting to trust and be trusted by others. The bereaved adolescent may fear trusting someone because they might lose them.

The behavioral response to the core issue of self-image in Phase I involves the conflict between seeking separation while resisting it. Two possible bereaved responses are becoming overly mature or "acting out." Either behavior is exhibited in an effort to gain attention and nurturance from others. In Phase II, the behavioral response is striving toward independence which may be exhibited in "fight" or "flight" responses. In Phase III, the behavioral response occurs when the adolescent considers commitment to another

person. This may result in overinvestment or withdrawal from that person.

The affective response in Phase I revolves around anxiety related to separation. They may be depressed and flat or agitated. The adolescent may feel ineffective at this stage. In Phase II, the affective responses are inconsistent due to fears of incompetence. In Phase III, the affective response is determined by the self-image they have achieved. They either feel worthwhile and accepted, or unlovable and rejected. These reactions are strongly influenced by the blow to the self-image caused by the death.

In a similar way, the authors look at each of the other core issues. Fleming and Adoph (1986) provide the following example:

> ...the isolation felt by survivors may be intensified in a 14-year-old who is immersed in the developmental task of distancing himself or herself from emotional ties with parents. When a parent or sibling dies, the surviving parent(s) are often unable to nurture the adolescent or, as the opposite may happen, tend to hold on too closely so that the adolescent may be unable to reach out for the comfort of peers. If the family encourages extreme autonomy, the youngster must struggle with this separation-reunion dilemma in isolation. The normal tasks of an adolescent of this age are now complicated and may be too taxing for immature abilities. Unable to negotiate appropriate emotional separation and left with protest or despair, the adolescent's future abilities to form intimate relationships are endangered. (p. 110)

Factors

Numerous factors have been identified as having an influence on the grief process. Many of these are examined in the sections on adult and child bereavement. In this section, some factors which have been identified as being related to adolescent bereavement will be discussed.

Characteristics of the adolescent. Zeligs (1974) believes that in addition to cognitive development, a child or adolescent's concept of death is based on his/her education, experiences with death, culture, religious beliefs, and how those around him/her approach death and grief. Also, the youth's intelligence and personality affect his/her concept of death.

Prior experiences with death also affect grief reactions. Adolescents today are less likely to have had an experience with death. Death is frequently confined to medical settings and is viewed as something that only happens to the aged. As a child, the adolescent was probably sheltered from experiences involving death. Because of this lack of experience, the adolescent has not learned how to cope with grief. According to Gordon (1986, p. 22), "nothing in previous experience has prepared the youth for the feelings of rage, loneliness, guilt, and disbelief that accompany a personal loss." Furthermore, society is uncomfortable with the topic of death and, therefore, it is not discussed openly.

Fuhrmann (1986) states that all adolescents must deal with both societal and developmental stress. She says the ones who cope maladaptively are those who were vulnerable due to having had a long history of problems. She also reports on a study that found most of the adolescents referred for psychiatric help reported more stressful events during the previous two years and as having less family support, as compared to a control group. Fuhrmann believes biological, intellectual, and social factors interact to determine adolescent adjustment to stress. She emphasizes the role the family system plays in determining adolescent adjustment.

Balk (1983) found age and sex to both be factors influencing grief reactions of surviving siblings. Teenagers in the 17 to 19 year old group were more likely to report having felt angry at the time of their sibling's death, while the younger teenagers were more likely to report feelings of shock at the time of the death. Females were more likely than males to report feeling confused about the death.

Race has also been examined as a possible factor influencing bereavement reactions. Gordon (1986) points out that blacks generally deal with death more openly. Black children are more likely to be exposed to death, and the rituals surrounding it, at a young age. Furthermore, the black community generally has a stronger religious

orientation. All of these factors make death less threatening to the black adolescent.

Characteristics of the deceased. The sex of the deceased and the sex of the bereaved were mentioned as factors influencing child bereavement. Zeligs (1974) believes this is also a factor in adolescent bereavement. She says an adolescent boy who loses his father may be expected to take his place in the family. The family may become dependent on him. She says this is detrimental to the son because this is a period when he needs to be concentrating on education, social and recreational activities, and making plans for the future. If the family puts too much pressure on him after his father's death, he may become angry, depressed, resentful and guilty. A teenage daughter whose mother dies may face a similar experience according to Zeligs. She may be expected to do household chores and care for younger siblings. Again, Zeligs believes that she should be focusing on her own social and educational life. She may feel isolated and alone, and may lose a sense of her own identity.

Little research has investigated the influence of the type of death on the bereavement process. This is particularly true in adolescent literature. Valente and Sellers (1986) addressed the issue of adolescent adjustment to a parent's suicide. They state that the adolescent must cope with "the stigma, rejection, and disillusionment that

accompany a suicidal death" (p. 167). He/she must deal with issues of self-blame and guilt. Valente and Sellers, while stating that suicide is one of the most difficult types of death for anyone to survive, believe it is particularly difficult for adolescent survivors because of their current struggle for their own identity. They point out that there are no data available of adolescent survivors of suicide but infer they are at high risk because adolescents and survivors of suicide both have increased rates of suicide.

The relationship between the survivor and the deceased is also an important factor in bereavement. The majority of studies have looked at parental loss in childhood and adolescence. There has been little research on the effects of sibling death in adolescence. The death of a child in a family, however, is considered to be one of the most difficult types of death with which to cope. Fleming and Adoph (1986) report that data suggest family maladjustment, following the death of a child, may last more than two years following the death. Balk (1983), in his study of the grief reactions and self-concept perceptions of adolescents following the death of a sibling, notes that there has been little research on sibling bereavement, in general, and no data exist on sibling bereavement in adolescents. While Balk believes a sibling death during adolescence may have long-term effects on the surviving sibling, he states that

it is important to investigate the possibility of positive outcomes, as well as negative ones.

Family characteristics. The role of the family is explored in greater detail in a previous section of this paper, but the specific role of the family in the adolescent's life will be discussed here. Fuhrmann (1986) states that the most important role of the family for the adolescent is in helping the adolescent to become autonomous while still providing emotional support. While the increasing importance of peers has been emphasized in the literature, Fuhrmann maintains that this does not exclude the continued influence of parents in the life of the adolescent. Fleming and Adoph (1986) report on a study by Connell et al. in which they found that the majority of adolescents confided in family members, primarily their mothers.

The need for familial support is complicated because all of the family members are grieving. Because they are all feeling pain, they may feel isolated from one another and find communication more difficult (Fleming & Adoph, 1986). Many bereaved people, and particularly adolescents, feel there are certain ways they "should" grieve. For instance, they may have feelings of guilt if they feel their grief has not been as intense or as long as it "should" have been (Fleming and Adoph, 1986).

Gerber (1985) reports that while the adolescent may want to regress, the adults in his/her life do not allow this. The parent(s) is dealing with his/her own grief, as well as economic and other concerns. The parent demands that the adolescent be mature. Adolescents are frequently told by parents or other adults to take on the responsibility held by the deceased parent. The adolescent may even feel forced into "parenting" the parent. Gerber believes this can seriously alter normal adolescent development.

Support system. Support from others is a factor often mentioned as affecting adjustment following the death of a family member. Gordon (1986) states that the adolescent often lacks support from others. Peers are frequently not supportive unless they have had a similar experience. They may even withdraw from the bereaved teenager because of their own anxiety and not knowing what to say or do (Gordon, 1986).

Reactions

Common grief reactions. Gerber (1985) reports on an unpublished study by Gapes which found the typical adolescent response to grief as one of escape. "Although the usual responses of guilt, anger, depression, anxiety, and confusion were present, the adolescents' frequently suppressed their emotional responses" (Gerber, 1985, p. 376). Gapes attributed this to the adolescents feeling

their peers would not accept them if they displayed these responses. The adolescents were concerned with displaying a "normal" response.

Fuhrmann (1986) distinguishes between two types of depression. The first, acute depression, she defines as a brief reaction to an identifiable loss. She views this grief response as adaptive because it allows the person the time to recuperate. She says this grief is characterized by sadness, anxiety, loss of motivation, and pessimism. This is differentiated from chronic depression which she believes results from earlier developmental deficits and is characterized by "unrealistic negative feelings, self-image, and expectations" (p. 413). This type of depression is less likely to have a quick recovery. The chronically depressed adolescent may remain withdrawn and isolated. Fuhrmann believes chronic depression is related to a combination of stressors and a lack of family cohesion. Fuhrmann points out that the young adolescent is more likely to display his/her depression through behavior such as "an inability to concentrate, fatigue, insomnia, physical complaints, boredom, restlessness, abuse of alcohol and drugs, acting out, promiscuity, failure, running away, and . . . accident proneness" (p. 412).

Parental death. When a parent dies, the young adolescent frequently regresses in an attempt for support from adults. This may delay him/her from pursuing autonomy

and independence. Gordon (1986) sees this regression as more problematic for the older adolescent because the family usually will not allow it. Instead, they push the adolescent into taking on additional responsibilities. Gordon believes a family should provide support and understanding to the adolescent while still encouraging him/her to pursue normal adolescent independence.

Long-term impact. Unresolved grief in adolescence can produce long-term effects. One possible outcome is when a person who loses a parent in adolescence spends the rest of his/her life looking for someone to fill the parental role in his/her life. Other effects include "staying home to care for mom or dad and never marrying or, feeling the tug of war between independence and inappropriate family responsibilities, severing ties to the family more quickly and permanently than would have occurred if the parent's death had not taken place" (Gordon, 1986, p. 25).

Sibling death. Balk (1983), in his study of sibling bereavement, found that emotional responses to the death had diminished from the time of the death to the time of the interview. The adolescents studied had lost siblings 4 to 84 months prior to the study. The length of time since the death did not appear to influence the respondent's perception of decreased grief feelings. Of the 33 adolescents studied, one-third still experienced such feelings as shock, guilt, confusion, depression, fear,

loneliness or anger at the time of the interview, and two-thirds reported having had these feelings in the month prior to the interview.

Balk found that two-thirds of the siblings reported having had problems sleeping after the death, but the respondents did not report problems in appetite. About half of the teenagers Balk studied reported thinking they had heard or seen their sibling since the death. Almost one-third reported having considered suicide within the first few weeks after the death and about a quarter had considered suicide since that time.

Two-thirds of the adolescents Balk studied said their study habits had changed following the death. About one-half had lower grades following the death. While most reported that their grades and study habits eventually returned to normal, about a quarter said they still had academic problems at the time of the interview.

Most of the adolescents reported having particular problems coping at holidays or the anniversary of the death. When asked how they dealt with this, they reported that they try to recall happy memories of the sibling, do things to get their mind off of their sibling, or talk to someone about their feelings.

In looking at the effects of the family on adolescent coping with sibling death, Balk found significant differences between the groups reporting high family

coherency as opposed to those reporting low family coherency. Family coherency was defined as frequency of talking to family members about personal matters and feelings of closeness to family members. Those adolescents reporting high family coherency were more likely to report feeling afraid, lonely or numb. Those with low family coherency were more likely to feel confused about the death, relieved it was over, angry at the time of the death, and feel guilty at the time of the interview.

Balk emphasizes that experiencing a sibling death can have positive effects, as well as negative ones. There was a significant difference between how mature the adolescent thought he or she was prior to the death, and how they felt at the time of the interview. The majority also reported having learned a lesson from the death. The lessons most frequently reported were "1) irrevocably bad things can happen in life; 2) people should be valued more while alive; and 3) there are ways to cope with adversity" (Balk, 1983, p. 149). Religion was also found to take on increased importance following the sibling's death, with the majority feeling religion had helped them cope with the death.

With regard to self-concept, Balk found that these adolescents were similar to norm groups on their self-concept scores in all areas except moral values. In the area of moral values, the bereaved adolescents showed better adjustment than the normative group.

Balk concludes from his research that while the sibling death had significantly impacted on the lives of these adolescents, the majority showed normal psychological adjustment. Furthermore, the death had a positive impact in terms of the adolescents' feeling of being more mature and reporting having learned from the death. Balk points out, however, that one-quarter to one-half report continued grief reactions. Balk sees the need for more research which would look at the reasons for the different coping levels of bereaved adolescents.

Summary

The review of the literature indicates that while a sizeable amount of research has been conducted in the areas of adult and child bereavement, little is known about the adolescent who is bereaved.

When looking at the little research on adolescents and death which has been conducted, methodological problems are found to be prevalent. Many studies have not considered age differences when looking at the impact of death on youth. Children and adolescents have often been included in the same studies without any analysis of age as a factor in adjustment (Fleming & Adoph, 1986).

A second methodological problem is that most of the research has been retrospective in nature. Instead of asking the adolescent about his/her experience with death, adults have been asked about their memories of their death

experience when they were adolescents. Other studies have asked parents to report on their adolescents' reactions to bereavement. The validity of such research is limited not only because the data are second-hand, but also because the responses of most of these parents may have been influenced by their being in mourning at the time.

Third, much of the research on the effects of child or adolescent bereavement has used clinical populations. Using samples of people in psychotherapy greatly limits the generalizability of the data to the general population.

Fleming and Adoph (1986) emphasize the need for more research in the area of adolescent bereavement. Some of the areas which they believe should be investigated include "looking more closely at age differences in bereaved adolescents . . . the impact of loss on the conflicts and tasks of normal adolescent development . . . sex role expectations . . . the possibility that death of a loved one can serve as a catalyst for constructive personality change . . ." and "bereaved adolescents within their grief-stricken families" (pp. 116-117).

This research project was designed to investigate several areas of adolescent bereavement. Data were collected on adolescents who had lost a parent in the two years prior to the study. All of the parents had died following a terminal illness. The research sought to look at the differences between the sample and a normative

population on personality variables. It also investigated the influence of age, sex, relationship of the deceased, time since death, amount of support received, and prior family configuration on both personality and adjustment variables. Lastly, this research sought to describe the experiences of this sample of bereaved adolescents.

At the present time, no adequate model for investigating adolescent bereavement exists. An additional problem is that no instruments have been developed to specifically look at this topic. It is for these reasons that this research involved the development of such a model and instrumentation. The data collected will provide a baseline for future investigations in the area of adolescent bereavement.

CHAPTER III
METHODOLOGY

This study was designed to investigate the experience of bereaved adolescents. This chapter is composed of a description of the sampling procedures, research procedures, benefits and risks, assessment instruments, research questions, definitions of variables, and data analysis procedures.

Sampling Procedures

Eighty adolescents, 11-18 years old, were identified as having lost a parent from January 1985 through April 1987. The parents who died had all been patients at Hospice Care, Inc., in Pinellas County, Florida. Hospice Care, Inc. is a corporation dedicated to serving terminally ill patients and their families. The criteria used by Hospice state that the patient must be referred by a physician, have a life expectancy of six months or less, and have a primary care giver. Hospice is a private, not for profit organization and, therefore, accepts all patients who meet these criteria regardless of their ability to pay. Hospice Care, Inc. offers the services of registered nurses, mental health counselors or social workers, home health aides, chaplains, and volunteers depending on the needs and requests of the

family. All families are also offered bereavement counseling for a full year following the death of their family member.

The 80 adolescents identified came from a total of 52 families. Forty-three were male and 37 were female. Thirty-six had lost a mother, while 44 had lost their father.

Research Procedures

All families were initially contacted by phone and told briefly of the study (Appendix A). They were told to expect a letter with a more detailed description of the study (Appendix B), consent forms (Appendix C), and research instruments (Appendix D) in the mail during the following week. They were sent a stamped, self-addressed envelope in which to return the instruments and consent forms. The consent forms were signed by both the participant and his or her parent or guardian.

A follow-up phone call was made to answer any questions the participants or their parents had regarding the study. They were then asked when they could complete the questionnaires and return them (Appendix A).

Following the collection and analysis of the data, all participants were sent a letter explaining the findings of the study.

Benefits and Risks

The potential benefit to the participants was that the study would provide them with an opportunity to reflect on

the loss of the parent, and particularly how their feelings had changed over time. It might also encourage the surviving parent and child to discuss the experience, thus opening up the lines of communication between them.

The only possible risk of this study was that it might have caused the participant to remember the death and re-experience some of the feelings connected with it. This would be particularly true in cases where there were unresolved issues connected with the parent's death. Therefore, all participants were offered the opportunity to talk with a Hospice counselor should they feel the need.

Assessment Instruments

A number of instruments were evaluated to determine which would best suit the purposes of this study. The instruments selected needed to have established norms, preferably with a population similar in age to that of the sample. The norms should be on a normal, rather than clinical, population. Due to the nature of the study, the use of established norms rather than a control group seemed preferable. It would not have been possible to administer the YBQ to non-bereaved adolescents, thus limiting the benefit of a control group. The instruments should look at normal coping behaviors rather than psychopathology. It was determined that two instruments would probably be necessary: one which would focus on the grief experience, and one which would focus on normal coping styles.

In a review of grief instruments, the few that exist focus on the loss of a spouse. Therefore, the author developed the Youth Bereavement Questionnaire (Appendix D). The Youth Bereavement Questionnaire (YBQ) was originally developed by the author as a clinical assessment tool to be used with adolescents being served by Hospice Care, Inc. It was expanded for the purposes of this study. The author relied on both clinical experience and the review of the literature to determine what factors were of most importance in assessing adolescent grief. The first section reflects factors considered to be of possible importance in influencing the bereavement reactions of adolescents. These included demographic, individual and family variables. Questions about the adolescent's family relationships and support system were also included. A number of questions were designed to be descriptive of the grief experience. The second section consists of commonly reported grief reactions. These can be divided into emotional, physical, behavioral and cognitive reactions. The participants were asked which of these reactions they experienced during the first month of bereavement, and which they were experiencing at the time of the study. A grief adjustment score for both the first month and the present time were computed by adding together the values of each response. The difference between the first month score and the present time score of

each reaction was also computed to determine if and how much of a change had occurred.

The Edwards Personal Preference Schedule (EPPS) was selected as the normative instrument because it appeared to be the best measure of normal personality variables based on the face validity of the instrument. The personality styles assessed by EPPS appeared to be ones which might be reactive to stress, and therefore reflect the individuals' style of dealing with a particular stressor. The EPPS was judged to have two limitations pertinent to this study. First, the normative population, to which this sample was compared, consists of college students. While being older than the sample, the EPPS college norms have been used in other studies of adolescents as well (Dixon & Ahern, 1973; Pasewark & Sawyer, 1979). The second limitation pertains to the ipsative nature of scoring the EPPS. While the use of Analysis of Variance with ipsative instruments requires cautious interpretation, ANOVA has been used with the EPPS on numerous occasions (Dixon & Ahern, 1973; O'Shea, 1970; Travis & Anthony, 1975). While these factors limit the generalizability of the data, the EPPS was felt to be the best instrument currently available. The 15 scales of the EPPS served as dependent variables in this study. These will be further discussed in the definition of variables.

Research Questions

This study attempted to answer several questions related to adolescent bereavement:

1. Are there differences between adolescents who have lost a parent to death and the normative group relative to scores on the EPPS?

2. Is there a relationship between age or sex and scores on the EPPS and the grief reaction scores on the YBQ?

3. Are there differences between those adolescents who had a father die and those who had a mother die relative to scores on the EPPS and the grief reaction scores on the YBQ?

4. Are there differences between bereaved adolescents from intact homes and those from divorced or separated homes relative to scores on the EPPS and the grief reaction scores on the YBQ?

5. Is there a relationship between length of time since the death and scores on the EPPS and the grief reaction scores on the YBQ?

6. What are the experiences of bereaved adolescents as reported on the YBQ?

Definitions of Variables

The following are the definitions of the 15 personality variables assessed by the Edwards Personal Preference Schedule as they are described in the manual (1959, p.11; Reprinted by permission of the publisher).

1. Achievement. To do one's best, to be successful to accomplish tasks requiring skill and effort, to be a recognized authority, to accomplish something of great significance, to do a difficult job well, to solve difficult problems and puzzles, to be able to do things better than others, to write a great novel or play.

2. Deference. To get suggestions from others, to find out what others think, to follow instructions and do what is expected, to praise others, to tell others that they have done a good job, to accept the leadership of others, to read about great men, to conform to custom and avoid the unconventional, to let others make decisions.

3. Order. To have written work neat and organized, to make plans before starting on a difficult task, to have things organized, to keep things neat and orderly, to make advance plans when taking a trip, to organize details of work, to keep letters and files according to some system, to have meals organized and a definite time for eating, to have things arranged so that they run smoothly without change.

4. Exhibition. To say witty and clever things, to tell amusing jokes and stories, to talk about personal adventures and experiences, to have others notice and comment upon one's appearance, to say things just to see what effect it will have n others, to talk about personal achievements, to be the center of attention, to use words that others to not know the meaning of, to ask questions others cannot answer.

5. Autonomy. To be able to come and go as desired, to say what one thinks about things, to be independent of others in making decisions, to feel free to do what one wants, to do things that are unconventional, to avoid situations where one is expected to conform, to do things without regard to what others may think, to criticize those in positions of authority, to avoid responsibilities and obligations.

6. Affiliation. To be loyal to friends, to participate in friendly groups, to do things for friends, to form new friendships, to make as many friends as possible, to share things with friends. to do things with friends rather than alone, to form strong attachments, to write letters to friends.

7. Intraception. To analyze one's motives and feelings, to observe others, to understand how others feel about problems, to put one's self in another's place, to judge people by why they do things rather than by what they do, to analyze the behavior of others, to analyze the motives of others, to predict how others will act.

8. Succorance. To have others provide help when in trouble, to seek encouragement from others, to have others be kindly, to have others be sympathetic and understanding about personal problems, to receive a great deal of affection from others, to have others do favors cheerfully, to be helped by others when depressed, to have others feel sorry when one is sick, to have a fuss made over one when hurt.

9. Dominance. To argue for one's point of view, to be a leader in groups in which one belongs, to be regarded by others as a leader, to be elected or appointed chairman of committees, to make group decisions, to settle arguments and disputes between others, to persuade and influence others to do what one wants, to supervise and direct the actions of others, to tell others how to do their jobs.

10. Abasement. To feel guilty when one does something wrong, to accept blame when things do not go right, to feel that personal pain and misery suffered does more good than harm, to feel the need for punishment for wrong doing, to feel better when giving in and avoiding a fight than when having one's own way, to feel the need for confession of errors, to feel depressed by inability to handle situations, to feel timid in the presence of superiors, top feel inferior to others in most respects.

11. Nurturance. To help friends when they are in trouble, to assist others less fortunate, to treat others with kindness and sympathy, to forgive others, to do small favors for others, to be generous with others, to sympathize with others who are hurt or sick, to show a great deal of affection for others, to have others confide in one about personal problems.

12. Change. To do new and different things, to travel, to meet new people, to experience novelty and change in daily routine, to experiment and try new things, to eat in new and different places, to try new and different jobs, to move about the country and live in different places, to participate in new fads and fashions.

13. Endurance. To keep at a job until it is finished, to complete any job undertaken, to work hard at a task, to keep at a puzzle or problem until it is solved, to work at a single job before taking on others, to stay up late working in order to get a job done, to put in long hours of work without distraction, to stick at a problem even though it may seem as if no progress is being made, to avoid being interrupted while at work.

14. Heterosexuality. To go out with members of the opposite sex, to engage in social activities with the opposite sex, to be in love with someone of the opposite sex, to kiss those of the opposite sex, to be regarded as physically attractive by those of the opposite sex, to participate in discussions about sex, to read books and plays involving sex, to listen to or to tell jokes involving sex, to become sexually excited.

15. Aggression. To attack contrary points of view, to tell others what one thinks about them, to criticize others publicly, to make fun of others, to tell others off when disagreeing with them, to get revenge for insults, to become angry, to blame others when things go wrong, to read newspaper accounts of violence.

A grief adjustment score was computed for the first month of bereavement and for the time of the interview. Grief reactions commonly reported in the literature are listed. The respondents were asked to indicate if these reactions were 1) not present, 2) somewhat present, 3) very much present, or 4) always or extremely present. The frequency of each reaction was computed for the

sample population. In addition, the total grief adjustment score was used as a dependent variable in this study.

Data Analysis

The independent variables in this study are age and sex of the adolescent, sex of the parent who died, length of time since the death, marital status of parents prior to the death, perceived support from others, and time since death.

The dependent variables in this study include the grief adjustment scores for the first month and the present time, perceived adjustment (question 54 from the YBQ), and the scores on the Edwards Personal Preference Schedule.

Initially, the sample was compared to the normative population on the EPPS through the use of t tests comparing the sample means to the norm means on each of the fifteen scales. These comparisons were conducted in order to determine if the sample was significantly different from the normative population on any of the fifteen scales. Simple t tests were also be conducted to compare the adjustment of the subjects on a number of variables during the first month of bereavement versus their coping at the time of the study. The relationship of the independent variables to the dependent variables were assessed by simple Analyses of Variance to determine what factors may have an influence on adolescent bereavement.

In addition, descriptive statistics were computed for a number of questions reflecting the experiences of bereaved adolescents. These included variables related to individual and family dynamics.

CHAPTER IV
RESULTS

Eighty adolescents, 11-18 years old, who had lost a parent by death, were identified for inclusion in the study. Of these, 15 had moved and the investigator was unable to obtain a forwarding address. Of the sixty-five contacted, 25 did not return the data, six refused to participate, and four completed the Youth Bereavement Questionnaire only and, therefore, could not be included in the study. Data was collected and analyzed for the remaining 30 participants.

Demographic Data

Data on the age, sex and relationship of the deceased for the subjects are presented in Table 1. The participants came from a total of 22 families. Ninety percent are white, while the other 10 percent came from one Vietnamese family. While the data show that the participants are now 12-20 years old, they were between the ages of 12 and 18 when the deaths occurred. Twenty percent were 12 or 13 years old, 30 percent were 14 or 15 years old, 40 percent were 16 or 17 years old, and 10 percent were 18 years old when their parents died. The majority of deceased parents were in their 40s and 50s at the time of death. Twenty percent of

the deaths occurred during the six months prior to the study. Only 3 percent had occurred between six and twelve months prior to the study. Twenty percent of the deaths occurred between 12 and 18 months, 30 percent had occurred between 18 and 24 months, and 27 percent had occurred one to two years prior to the study.

Table 1
Age, Sex, and Relationship of Deceased Characteristics of Sample

Age	Male		Female	
	Father	Mother	Father	Mother
12	1			
13	1		1*	
14	1		1	
15		2	1	
16	1		1,1*	
17	1	2	2	4
18	2		2	1
19			3	1
20	1			

*stepfather died

While all of the parents who died were ill for at least a month before the death, and over 70 percent were ill for more than a year, the participants did not realize their parents were terminally ill for that long. Thirteen percent said they knew their parent was terminally ill for less than a week before the death. Seven percent knew for one to four weeks, 30 percent knew for one to six months, 23 percent knew for six to twelve months, and 27 percent knew for more than a year that their parent was going to die.

Thirty-seven percent of the participants were Catholic, 44 percent were Protestant, 3 percent said they had some other religious affiliation, and 17 percent said they had no religious preference. Eighty-three percent said that there was a funeral for their parent and in all of those cases the child attended the funeral. Of the others, only one expressed a regret that they were unable to attend a funeral for their parent. An approximately equal number of subjects were oldest, middle and youngest siblings in their families. None were only children.

Ninety percent of the subjects came from families in which their parents were married to each other at the time of death. Two of the participants, however, whose parents were married, said their parents were separated at the time of the death. Of the three whose parents were not married, two came from divorced households, and one had experienced the death of the other parent previously. All participants had at least daily contact with their ill parent before the death.

Since the death of the parent, 90 percent live in the same house as they did prior to the death. Of the surviving parents, 57 percent are not dating, 23 percent are dating, and 10 percent have remarried. Eighty percent of the surviving parents are employed. Half of those who were not working at the time of their spouse's death have begun to work since the death.

The majority of participants had experienced the death of a family member or friend prior to the death of their parent. Ninety-seven percent had lost a grandparent. Forty percent of the subjects said they had experienced the death of someone close to them. Nine of the subjects had lost a friend, two had lost a sibling, and one had lost the other parent.

While all of the subjects' parents had been Hospice Care patients, only 30 percent said they had received direct counseling concerning the death of their parent. In response to the question of whether the subject wanted to be contacted by a Hospice Care counselor, only four answered affirmatively. All of these were female. Three were either 17 or 18 years old, had lost their mother, and the death had occurred within six months of the study. The one other participant who requested counseling was thirteen years old, had lost her step-father, and the death had occurred 1 and 1/2 years prior to the study. It should be noted that this participant had participated in Hospice Care bereavement services throughout the year and a half.

Descriptive Data

The participants answered 29 questions concerning family relationships and reactions to the death. The means and standard deviations of responses to these questions are presented in Table 2.

Table 2
Means and Standard Deviations of Responses to Descriptive Questions 31-60 from the YBQ

Question	Mean	SD
Before my parent died, we had a good relationship.	3.43	0.73
My relationship with my living parent is good.	3.07	0.88
I am closer to my living parent now than I was before the death occurred.	2.52	0.95
My relationship with my brothers and sisters is good.	2.83	0.66
My living parent was supportive and helpful to me after my parent died.	3.03	0.94
My brothers and sisters were supportive and helpful to me after my parent died.	2.79	0.94
My friends were supportive and helpful to me after my parent died.	3.30	0.79
My teachers were supportive and helpful to me after my parent died.	2.37	0.96
I believe my living parent got more sympathy from others than I received.	1.90	0.86
Before my parent's death, he or she and I talked about him/her dying.	2.13	0.90
My family talked openly about the fact that my parent was going to die.	2.10	0.96
My family has talked openly about our feelings since my parent died.	2.20	0.81
My family is closer now than before the death.	2.33	0.84
I have to help more at home than I did before my parent died.	2.80	0.85
I have more responsibilities now than before my parent died.	3.17	0.70

Table 2 Continued

Question	Mean	SD
I have more freedom now than before my parent died.	2.30	1.02
In my family, it is alright to talk about our feelings (e.g., sadness, anger, guilt, etc.)	2.87	1.01
In my family, we participate in recreational activities together.	2.07	0.87
I felt relieved when my parent died.	1.60	0.81
I believe my parent could have prevented his or her death.	1.30	0.65
My family is well adjusted and has few problems.	2.37	0.89
We have had financial problems since my parent died.	1.80	1.06
My religious beliefs helped me deal with the death of my parent.	2.13	1.11
I have had difficulty adjusting to my parent's death.	2.20	0.76
My living parent has had difficulty adjusting to my parent's death.	2.48	0.74
My brothers and sisters have had difficulty adjusting to my parent's death.	2.24	0.58
Having a parent die has made me a stronger person.	2.43	0.86
Having a parent die showed me who my friends really are.	2.67	0.92
Having a parent die caused me to evaluate my values or change things I was doing in my life.	2.37	0.76
I get upset whenever I think of my parent who died.	2.53	0.86

Note: Respondents could answer in the following categories
1--Not at all
2--A little or somewhat
3--Very much
4--Always or extremely

The subjects had been asked to respond on a four point scale to the questions with one being no experience and four being a strong experience. With regard to the descriptive questions asked of the subjects, only five had means over 3.0. Two of the questions on which the subjects had a mean over 3.0 were their descriptions of their relationships with their deceased parent prior to the death, and their relationship with their surviving parent. Two other questions which had means over 3.0 dealt with the feeling of support these adolescents reported they received from their living parent and from peers. The last question which had a mean over 3.0 was that of feeling that they had more responsibilities than before the death.

Statistical Analyses

Initially, the sample of 30 bereaved adolescents was compared to the college norm population on the 15 scales and consistency scale of the Edwards Personal Preference Schedule (EPPS). The results of these comparisons are found in Table 3. The sample was found to differ significantly from the norm population on eight of the scales and on the consistency variable. The consistency variable indicates whether or not a subject's scores are likely to be valid. Eight of the subjects were found to have consistency scores below the cut-off indicating that their responses were of questionable validity.

Table 3
Comparison of Sample to Norm Population on EPPS

Scale	t
Achievement	1.44
Deference	-3.56*
Order	-1.87
Exhibition	3.14*
Autonomy	1.77
Affiliation	0.26
Intraception	-3.36*
Succorance	2.30*
Dominance	-3.17*
Abasement	0.49
Nurturance	2.06*
Change	0.20
Endurance	-0.55
Heterosexuality	-3.00*
Aggression	2.86*
Consistency	-3.55*

* $p < .05$

The investigator sought to determine the characteristics of the eight participants whose data was questionable and to see if the statistical analyses would vary greatly if these eight were not included in the comparisons. While the average age of the 30 subjects was 16.6, the average age of the low consistency group was 14.7. The distribution of male versus female, and relationship to the deceased were virtually the same for the two groups.

With regard to the statistical analyses, removing the low consistency group from the calculations did affect some of the results. For example, as noted in Table 3, with n=30, eight of the scales showed a significant difference between the sample and the norm. However, with n=22, after the low consistency subjects' data was removed,

Intraception, Heterosexuality and Aggression were no longer found to be significant. On the other hand, Order showed a significant difference with n=22 while it had not for n=30. In general, however, the two groups were similar in the analyses. For that reason, the data presented will reflect the entire sample of 30 subjects.

From the Youth Bereavement Questionnaire, questions 61-88 were identified as adjustment variables. Table 4 presents the means for each of the variables for the first month following the death and for the present time. A t value was computed to determine if the subjects had experienced a significant change in any of the variables between the first month and the present time.

Analyses of Variance were conducted to determine the relationship between the independent variables of age, sex and relationship of the deceased to the dependent variables consisting of the 15 scales of the EPPS, the grief adjustment scores for the first month of bereavement and the time of the study, and perceived adjustment. A three-way Analysis of Variance was considered, but due to the small sample size, two one-way Analyses of Variance had to be conducted. The results are presented in Tables 5 and 6.

Table 4
Mean Values for Grief Reactions at First month after death and at Present Time, t test value for change

Reaction	1st month Mean	Present Mean	t
Headaches	1.63	1.46	1.28
Muscle Tension	1.72	1.55	1.57
Stomach	1.79	1.62	0.63
Appetite	1.45	1.31	1.16
Eating too much	1.59	1.66	0.00
Sleep disturbance	1.69	1.55	0.92
Nightmares	1.21	1.17	0.77
Weakness	1.76	1.41	2.58*
Depression	2.59	1.83	3.78*
Anger	2.13	1.54	3.86*
Guilt	1.72	1.31	3.15*
Fear	2.10	1.62	3.33*
Shock	1.70	1.21	2.58*
Loneliness	2.67	2.17	2.35*
Suicidal	1.47	1.18	2.12*
Anxiety	1.72	1.55	1.44
Substance Use	1.17	1.21	-0.33
School Problems	1.93	1.39	2.05
Withdrawal	2.21	1.73	2.82*
Moodiness	2.27	1.64	3.23*
Crying	2.59	1.83	4.04*
Keep Busy	2.28	1.97	1.91
Trouble	1.43	1.36	0.50
Concentration	2.47	1.75	3.87*
Thoughts re: deceased	3.21	2.69	2.75*
Confusion	2.00	1.79	1.69
Helplessness	1.97	1.43	2.75*
Thoughts about death	2.60	2.04	3.62*
Total Adjustment	54.83	43.93	4.10*

* $p < .05$

Note: Respondents could answer in the following categories:
1--Not at all
2--A little or somewhat
3--Very much
4--Always or extremely

Table 5
Relationship of Age and Sex to EPPS Scales, Adjustment 1st Month, Present Adjustment, Change in Adjustment, and Perceived Adjustment (F Values)

Scale	Age	Sex	Age X Sex
Achievement	0.21	0.30	0.22
Deference	1.95	2.54	0.22
Order	3.06	6.66*	0.79
Exhibition	2.11	1.03	0.85
Autonomy	0.59	1.56	2.33
Affiliation	0.14	5.02*	1.19
Intraception	3.19	9.28*	1.99
Succorance	0.53	0.03	0.72
Dominance	0.03	0.69	1.44
Abasement	14.26*	1.69	1.13
Nurturance	1.50	2.87	0.01
Change	0.24	9.13*	0.08
Endurance	0.38	5.57*	0.07
Hetero-sexuality	2.10	1.72	3.37
Aggression	0.38	0.01	0.00
Consistency	4.05	1.75	0.08
1st Month Adjustment	1.50	6.05*	2.57
Present Adjustment	0.04	3.44	0.03
Change in Adjustment	1.57	0.84	2.91
Perceived Adjustment	0.03	1.12	1.61

* $p < .05$

The ANOVA Summary Table is presented in Appendix E.

Table 6
Relationship of Sex and Relationship to the Deceased to EPPS Scales, Adjustment 1st month, Present Adjustment, Change in Adjustment, and Perceived Adjustment (F values)

Scale	Sex	Deceased	Deceased X Sex
Achievement	0.05	0.30	0.98
Deference	1.53	1.53	3.28
Order	5.76*	0.32	0.40
Exhibition	0.20	0.70	8.43*
Autonomy	0.02	1.06	3.48
Affiliation	5.84*	0.03	1.18
Intraception	18.30*	7.25*	1.02
Succorance	0.50	0.08	2.45
Dominance	0.00	0.07	3.46
Abasement	0.08	0.26	2.02
Nurturance	7.35*	0.01	3.89
Change	7.45*	0.11	1.27
Endurance	5.01*	0.43	1.13
Hetero-sexuality	3.62	0.42	2.91
Aggression	1.01	0.22	5.36*
Consistency	4.23*	4.23*	0.39
1st Month Adjustment	5.89*	0.04	0.84
Present Adjustment	3.00	0.01	0.04
Perceived Adjustment	0.02	0.02	3.39

* $p < .05$

The ANOVA Summary Table is presented in Appendix F.

As can be seen in the Tables, Sex was found to be statistically significant for Order, Affiliation, Intraception, Change and Endurance. In the cases of Affiliation, Intraception, and Change, females had significantly higher means than did the males in the sample. It should be noted, however, that the normative population also had statistically significant different means for males and females in the same direction for these same scales.

For the scales of Order and Endurance, the males had significantly higher means than did the females. The sample was divided into two age groups with "older" being subjects 17 and over, and "younger" being subjects 16 and below. Age was found to be significant for only one scale, Abasement, with the older subjects having a higher mean than the younger subjects. The relationship of the deceased was also only significant for one scale, Intraception. For that scale, those subjects who lost a mother had a significantly higher mean than did those who had lost a father. Interaction effects were found for two scales. On Exhibition, daughters who lost a father and sons who lost a mother had significantly higher means than daughters who lost a mother and sons who lost a father. The same interaction was found for Aggression. With regard to the adjustment variables, only one was found significant. Females had a significantly higher mean for their first month adjustment score than did the males.

Analyses of variance were also calculated for the same dependent variables with time since death and support as independent variables. Support received was calculated as the total perceived support from questions 35-38 of the YBQ. None of these comparisons were found significant.

CHAPTER V
DISCUSSION AND SUMMARY

Overview

The author's clinical experience with bereaved youth suggested that the loss of a parent during adolescence can be particularly traumatic. An extensive review of the literature, however, revealed that there has been little investigation into this area of grief and bereavement. Furthermore, much of the research which does exist is methodologically flawed. Frequently, adults are asked to reflect on a loss experience from their childhood or adolescence. The research has generally failed to look at age differences, tending to consider children and adolescents as one homogenous group. Furthermore, much of the research has looked at the bereavement reactions of clinical populations, thereby failing to distinguish the characteristics of bereaved individuals from the general population. Lastly, there is little connection between the theoretical and empirical literature. The theoretical literature has come primarily from clinicians and there has been little empirical research to support to reject it. On the other hand, the empirical research is rarely tied to theory.

Theory

A review of the theoretical literature on grief and bereavement found a number of theories which tend to look at different aspects of the grief reaction. The psychoanalytic perspective focuses on the detachment of the libido from the lost object with the eventual reinvestment in new relationships. Many of the psychoanalysts believe that children are not capable of mourning, but that mourning is possible by adolescence. The psychoanalytic theory predicts that ambivalent relationships are most likely to produce a pathological grief response.

A number of stage theories have been developed which state that grief occurs in sequential stages. The stages usually consist of 1) shock and denial, 2) depression, anxiety and anger, and 3) acceptance. More recently, however, clinicians have discounted the stage theories because of the finding that grief does not appear to occur in sequential stages. While the reactions described by stage theories are fairly consistent, the current understanding of grief is that these reactions can occur simultaneously and that there are progressions and regressions throughout the process.

Some of the less developed theories of grief include Caplan's crisis theory, Ramsay's cognitive theory, Gauthier and Marshall's behavioral theory, and Family Systems' theory. While the crisis theory focuses on the equilibrium

that is disrupted, cognitive theory focuses on the individual's perception of the event and feelings of helplessness, and behavioral theory looks at the positive reinforcement received for the grief reactions and the loss of reinforcement from the deceased. Family Systems' theory is a relative newcomer in the field of grief and bereavement. The focus of this theory is on role relationships, communication patterns, cohesion, and adaptability.

Particular to the field of childhood bereavement is a focus on a child's cognitive development, particularly the child's concept of death. Theoreticians vary in terms of when they believe a child's understanding of death is fully developed, but agree it is fairly complete by adolescence. There is little known about the connection between a child's concept of death and their grief reaction.

While it is generally agreed that adolescence is a distinct stage of development, there is less agreement on its characteristics. For many years, adolescence was described as a period of turmoil, anxiety and rebellion. More recently, however, this has been called into question, with empirical research not bearing this out. It is agreed, however, that adolescents do develop increasing independence during this period and also move from parents to peers as a primarily means of support.

Fleming and Adoph have developed a theory of adolescent grief which looks at three stages of adolescence. They believe each phase confronts a particular task, that of independence from parents, competence and mastery, or intimacy, depending on age. They then look at how each stage deals with five core issues from a cognitive, behavioral and affective perspective.

Although all the theories contribute to the study of grief and bereavement, there has been little empirical research to support them. Furthermore, they have failed to generate testable hypotheses, such as who would be most likely to have a pathological grief reaction. The bridge between theory and research has not yet been linked.

Factors

Much of the empirical research has sought to look at the factors affecting grief and bereavement. There are few conclusive findings, however. One factor generally agreed to impact of the grief process is that of forewarning or preparation for the death. While it has been found that people generally cope better with a death that they expected, a particularly long terminal illness can be just as detrimental as no preparation at all. It appears that preparation has a curvilinear effect on grief, with some preparation, but not too long, being most beneficial. The quality of the relationship between the individual and the deceased prior to the death is believed to significantly

impact of the bereavement outcome. Relationships characterized by ambivalence, anger or dependency are more difficult for the bereaved individual than are more positive relationships. Although sex and age have both been investigated, the findings are inconclusive. It is generally believed that while men and women have different grief reactions, neither is thought to be more or less healthy. Women are said to have more emotional and somatic reactions, while men are more likely to be in denial. In children, little is known about the differences between bereaved boys and girls, nor is much known about the effect of age on bereavement outcome. With regard to the type of death, homicide and suicide survivors are believed to have the most difficulty resolving their grief. While prior experience with death is thought to impact on the grief reaction, it can do so positively or negatively depending on the resolution of the previous loss. Other stressors faced by the individual or family, such as financial problems, change of residence, etc. are believed to negatively impact on the grief reaction. The more support a person receives, the more likely they are to resolve their grief in a positive manner.

Reactions

Much of the empirical literature has sought to describe bereavement reactions. They have generally been classified as emotional, behavioral, cognitive or physical. The most

common emotional reactions are shock, depression, anger, guilt, and anxiety. The common behavioral reactions are regression, withdrawal, irritability, and use of alcohol or drugs. Common cognitive reactions are difficulty concentrating, preoccupation with thoughts of the deceased, and disbelief. The most common physical reactions are insomnia, loss of appetite, shortness of breath, muscle tension, and lack of energy. Grief reactions in children have been found to be fairly similar to that of adults except that they are more likely to express their grief through behavioral and physical reactions than emotional or cognitive ones. Common childhood reactions are regression, academic problems, idealization of the deceased, hostility, fear, withdrawal, insomnia and loss of appetite. Adolescents are thought to be more likely to hide their feelings about the loss and to want to escape. Adolescents have been shown to display such behavioral reactions as difficulty concentrating, insomnia, acting out behavior, and academic problems. Pathological grief reactions vary in intensity and duration, rather than in type, from normal grief reactions.

Limitations

This study sought to look at adolescent bereavement. Because of the paucity of research in this area, the goal was to develop a model and instrumentation for such research and collect baseline data. The field is too sparse to look

at theory at this time. Due to the nature of this study, a number of limitations are inherent.

One of the primary limitations of this study is in the generalization of the findings to a larger population of adolescents. Data was collected on only thirty subjects. These subjects had all experienced the loss of a parent from a terminal illness, and all of the parents had been patients at Hospice Care, Inc., a home-based Hospice in Florida. This population may be skewed in favor of intact families because of the Hospice requirement that a primary caregiver be present in the home. Furthermore, it should be noted that no blacks participated, and only one minority family (a Vietnamese family) participated. Hospice families may tend to be white because it is a group who sought help from a community service organization. Minority families may be more likely to look within their own communities for support. Of the original identified group of eighty subjects, only sixty-five could be found, and of those, only thirty participated in the study. The characteristics of those who participated may be different from those who did not participate. It should be stressed that participants received no pressure to participate. While the majority who did not participate did not give a reason, one father said he did not want his daughter reminded of her mother's death. Several mothers commented, on being contacted, that they

doubted their children would take the time to complete the questionnaires.

A second major limitation of the study was the unavailability of adequate instrumentation. The investigator sought to find an instrument which would assess adolescent coping. No such instrument was found to exist. The Edwards Personal Preference Survey was selected because it looks at normal personality characteristics which appear might be affected by external stressors. The normative group, however, was that of a college population, and therefore, not the same as the sample. Due to these limitations, the results must be cautiously interpreted. It can not be determined if the differences found between the sample and normative groups are due to the grief experience, or existed prior to the study. The Youth Bereavement Questionnaire was developed by the investigator because no adequate instrument existed. Because this was its first application, however, the results must be viewed with caution.

A third limitation is that due to the small sample size, a limited number of analyses were conducted. If more analyses had been considered the risk of false positive results would have risen. Therefore, it was determined best to investigate a few focal issues.

Conclusions

The first research question was

> Are there differences between adolescents who have lost a parent to death and the normative group relative to scores on the EPPS?

The sample and norm groups were found to be significantly different on eight of the EPPS scales. The scales were: Deference, Exhibition, Intraception, Succorance, Dominance, Nurturance, Heterosexuality, and Aggression. They were also found to be different on the Consistency variable which reflects the validity of the responses. The sample was found to have significantly higher means on Exhibition, Succorance, Nurturance, and Aggression. Exhibition, Succorance and Aggression all relate to an individual's way of seeking attention. It appears that the bereaved group seeks attention through any avenue it can. The high score on nurturance likely reflects this group's unique quality of having watched, and probably cared for, a terminally ill parent. It is not surprising that this group would be more nurturant than others their age. The sample group had significantly lower means on the scales of Deference, Intraception, Dominance, and Heterosexuality. The low score on Deference would indicate that this is a more independent group than the norm, having learned to take care of themselves. The bereaved group not only lost a parent to death, but many lost the other parent to their own grief. This group may have had to cope by acting on their own

without the direction of others. The fact that they were found to be less intraceptive seems to support the literature in the statement that adolescents frequently cope with their grief through escape. By avoiding intraception, they can avoid thoughts of their loss. The sample group was found to be less dominant than the norm group. While they are not deferent, they do not like to lead others either. They will act independently, but do not want to be thought of in a leadership capacity. Finally, this group scores low on heterosexuality. One explanation is that this group is younger than the college norm population, and probably less involved in heterosexual activities than the older group. Another possible explanation, however, is that the bereaved group may have regressed due to their loss, and may have spent so much time focusing on their parent, as well as themselves, they have not yet developed the normal heterosexual feelings for their age group. Finally, the sample was found to be significantly different on the consistency variable and eight of the subjects had consistency scores below the cutoff, thus questioning the validity of their responses. It is possible, that because this group is younger, it is more likely to have questionable validity scores. In looking at this group, it matched the entire sample in terms of sex ratio, and loss of mother versus loss of father, but while the overall sample mean age was 16.6, the low consistency group had a mean age

of 14.7. It should be noted that the relationship of the deceased to the subject was found to be significant in terms of the consistency variable, with subjects experiencing the loss of a father having a significantly lower mean than the subjects who had lost their mother.

The second research question was

> Is there a relationship between age or sex and scores on the EPPS and the grief reaction scores on the YBQ?

Age was found to be significant in terms of only one dependent variable, Abasement on the EPPS. The older subjects had a significantly higher mean on this variable than did the younger subjects. It appears that the older group have more internalized guilt feelings and feelings of inadequacy. It is likely that this group places higher expectations on themselves for handling their grief, and in their pain, feel they have done a poor job.

Sex was found to be significant for the scales of Order, Affiliation, Intraception, Change and Endurance. Since the norm population also showed a significant difference between the sexes, and in the same direction as the sample, on Affiliation, Intraception, and Change, it does not appear that being bereaved was a factor. On the other hand, males had significantly higher means on Order and Endurance, and this was not found in the normative population. It appears that bereaved males have a greater need for order and organization than do bereaved females. They are also more likely than the bereaved females to need

to complete a task. Both of these characteristics relate to issues of control, a feeling these males likely lost when their parent died. In seeking to order their world, they are trying to reinstill a feeling of control in their lives. This is consistent with prior research which indicated that men tend to deal with their grief pragmatically, with a focus on what needs to be done, rather than on their emotions (Glick et al., 1974; Lagrand, 1986). No age by sex interactions were found.

The third research question was

> Are there differences between those adolescents who had a father die and those who had a mother die relative to scores on the EPPS and the grief reaction scores on the YBQ?

The relationship of the deceased was only significant for one scale, Intraception. Those subjects who had lost a mother had significantly higher means than did those who had lost a father. Family systems' theory would suggest that the father's role is more instrumental, while that of the mother's is more emotional. It appears that the loss of a mother leads to more analysis of one's own feelings than does the loss of a father. An interaction between sex of the subject and sex of the deceased was found on two scales, Exhibition and Aggression. On both scales, subjects who lost an opposite sex parent had significantly higher means than subjects who had lost a same sex parent. It appears that attention seeking behavior may be more likely when an opposite sex parent dies. While in the childhood grief

literature, the importance of the same sex parent for sex role identification was stressed, it appears that the opposite sex parent for the adolescent may have greater importance. At this age, when opposite sex peer relationships are developing, the loss of the opposite sex parent seems particularly significant.

The fourth research question was

> Are there differences between bereaved adolescents from intact homes and those from divorced or separated homes relative to scores on the EPPS and the grief reaction scores on the YBQ?

It was not possible to conduct this analysis because there were not enough subjects from divorced or separated homes. The majority came from intact families. As previously mentioned, the Hospice population may be skewed towards intact families due to the requirement that there be a primary caregiver in the home.

The fifth research question was

> Is there a relationship between length of time since the death and scores on the EPPS and the grief reaction scores on the YBQ?

Time since death was not found to be statistically significant in relation to any of the dependent variables. This finding substantiates the current state of the literature which has questioned stage theories of grief. It appears that grief reactions are individualistic in terms of time since death, and the length of the grief has little bearing on its resolution. Whether stages do occur, but varying in lengths of time, was not able to be determined by

this study. In response to questions about grief reactions, however, fifteen of the reactions showed a significant decline between the first month following the death and the present time. This is consistent with Balk's findings in his study of adolescents who had lost a sibling. While the length of time since the death does not appear significant, bereaved adolescents perceive that their reactions are decreasing. The majority of reactions which showed this significant decline were emotional reactions, while the subjects did not report significant declines in their physical, behavioral, and cognitive reactions. Because these are self-reports, it may be easier for these adolescents to repress their emotional reactions from immediate awareness, while the other, more overt reactions, are more difficult to suppress. It appears that while these adolescents are perceiving an improved emotional state, their grief experience continues to have an impact on their lives for a long period of time.

The sixth research question was

> What are the experiences of bereaved adolescents as reported on the YBQ?

As noted in the review of the literature, while it was previously thought that adolescents were in rebellion with their parents, the students in this study report that they generally consider their relationships with their parents quite good. In contrast to the child bereavement literature which has shown that children tend to idealize the deceased

parent while devaluing the surviving parent, this sample of bereaved adolescents report positive feelings toward both parents.

The sample reports feeling supported by both parents and peers. While the mean for peer support is slightly higher, it is interesting that, in contrast to the literature, these adolescents reported that they receive support from their parents as well as their peers. Also, it should be noted that the surviving parent's own grief did not prevent them from being supportive of their child. In contrast to the literature, this group did not seem to think their parent had received more sympathy than they received. Furthermore, much of the literature had suggested that adolescent peers shun the bereaved adolescent out of fear of not knowing what to say. These findings do not reflect this.

The adolescents in this study report feeling that they have more responsibilities than they did prior to the death of their parent. While it is true that the group is older now, and therefore, probably would have been having increasing responsibilities at home, it is possible that bereaved adolescents, in particular, may take on more responsibilities in the absence of their deceased parent.

Of the questions directed at expression of feelings in the family, the mean for talking with the parent prior to his/her death was 2.13, the mean for talking with the family

since the death was 2.10, and the mean for permission to express feelings was 2.87. It would be predicted that the families electing to have Hospice support would probably be more open, in that to get Hospice services there must be some recognition on the part of family members that the life expectancy for the patient is six months or less. With this in mind, the above means would indicate that expression of grief is still not widely accepted, and that, in general, these adolescents felt they could not talk about their feelings with family members.

When looking at the results concerning perceived support, the effect of support on adjustment, and family communication, it is interesting to note that while these adolescents report feeling supported, they did not generally feel able to discuss their grief experience. Furthermore, the support did not seem to have a bearing on adjustment. Future investigation should look at the quality of support received by adolescents. This study would suggest that adolescents' definitions of support probably vary widely and perhaps the type of support received has greater bearing than the amount received.

Few of the adolescents in this study report feeling that religion had helped them deal with their grief. Also, this group generally does not report positive outcomes from the grief experience, such as value clarification. This is fairly consistent with the finding that this group was less

intraceptive than the normative population. This is particularly important when considering that the group who chose not to participate in the study are likely to be even less willing to look inward.

Previous research suggests that one reason adolescents might have difficulty in their grief is because they have little prior experience with death. The research states that since there is less contact with "extended families" than in the past, combined with increased longevity, young people do not have to deal with death often. The results of this study contradict this prediction. Over ninety percent of the sample has experienced the death of a grandparent, and forty percent state they have experienced the death of someone "close" to them.

The subjects recorded their grief reactions on a four point scale with one and two being no or little experience of a particular reaction, and three and four being a lot or an extreme experience of the reaction. In the first month following the death, the subjects' mean on eleven of the symptoms is over 2.0. These included four of the eight emotional reactions, four of the seven physical reactions, and three of the five cognitive reactions. None of the eight physical reactions had a mean over 2.0. The literature suggested that both adult women and children frequently display physical symptoms in response to grief. This does not seem to be true of this sample of bereaved

adolescents. Similar to children, this group had several behavioral reactions with means over 2.0. In contrast, however, their behavioral reactions are withdrawal, moodiness, crying, and keeping busy, rather than acting out behavior. It appears that these adolescents direct their grief inward rather than outward. This groups does not reflect a high level of shock, and in the descriptive section, they did not report feelings of relief.

In comparison to the first month, only two reactions continue to have means above 2.0 at the time of the study. They are loneliness and thoughts of the deceased. While it appears that most adolescents are able to rebuild their lives and reestablish healthy functioning, they are left with an emptiness that continues long after the death.

Implications for the Future

This is only the beginning of what needs to be major research in the area of adolescent bereavement. It is a far too common occurrence that has been practically ignored by researchers and theoreticians alike.

In the area of theory, a carefully developed model is needed that can be used to generate hypotheses that can provide a direction for future research. Furthermore, theory needs to look specifically at the bereaved adolescent. At this time, only one theory has sought to do this.

Research is needed which can look at a larger number of bereaved adolescents, and look at those who have had sudden losses as well as those who lost a family member to a terminal illness. Longitudinal research which would follow bereaved adolescent over time would be particularly useful in more closely examining the grief process. Future research should look more closely at factors influencing grief resolution. In particular, questions about the quality of support received, and the sex of the deceased in relation to the sex of the bereaved, require more detailed investigation. In addition, future studies should also look at investigating the differences between emotional, physical, cognitive and behavioral reactions and possible reasons for perceived differences among them. Lastly, more adequate instruments need to be developed. In retrospect, the EPPS is not an adequate instrument for studying the experience of bereaved adolescents. Both due to the ipsative nature of scoring, and the age of the normative population, the EPPS has limited generalizability for this population.

Clinically, these findings can be taken tentatively. It appears that these bereaved adolescents tend to act out their grief rather than think about it. Furthermore, the loss of an opposite sex parent appears to be particularly predictive of this acting out behavior. While adolescents feel supported by both family and friends, they do not feel

free to talk about their feelings. Clinicians need to particularly look at the need for opening lines of communication within a family facing the death of one of its members.

APPENDIX A
PHONE CALL FORMAT

Initial Phone Call

This is Margaret Hodges with Hospice Care's Children's Support Program. How have you been getting along?

I am calling because we are trying to learn more about how youth cope with the death of a parent. We are hoping that your child (children), (name of child), can help us. We have a couple of questionnaires that we would like him/her to fill out. It should only take about 45 minutes to complete. Little is known about the experiences of youth in your child's age group. The more we can learn about this area, the better we will be able to help others deal with this traumatic experience. The information will be kept completely confidential.

I am sending the questionnaires to your child. Please look over them with him/her. There is a consent form I need for you to sign agreeing for your child to participate in the study. I'll call back in about a week to see if you or your child have any questions.

After we collect all the questionnaires, we will send you information about what we have learned.

Let me make sure that the address I have for you is correct. (verify address)

Thank you for your help.

Second Phone Call

This is Margaret Hodges with Hospice. Did you receive the materials I sent you? Do you or your child have any questions?

I need to have the materials returned to me as soon as possible. When does he/she plan to complete the questionnaires and return them to me? Please make sure your signed consent form in enclosed with the other materials. Once we have collected all the data, we will send you information about our findings. Thank you for your help.

APPENDIX B
LETTER

Dear

Coping with the death of a family member is difficult for anyone, but the death of a parent while still in middle or high school can be particularly difficult. Unfortunately, little is known about this experience. In connection with my doctoral studies, we are trying to learn more about what it is like to lose a parent. We need your help. The more we know, the better able we will be at helping others who must deal with the death of a parent.

Enclosed are some questionnaires for you to complete describing yourself and your experience. Your answers will be kept confidential. No one will know how you completed these questionnaires.

We have enclosed a stamped, self-addressed envelope for you to use to return the questionnaires. In addition, there is a permission slip we need to have signed by your parent agreeing that you can complete the questionnaires. We need to have the questionnaires and consent form returned within the next week so we can give you feedback about how you and others described your experiences.

It is extremely important to us to get information from all the youth we know who experienced the death of a parent. Your information is very valuable to us. Please let me know if you have any questions.

Sincerely,

Margaret H. Hodges, Ed.S.
521-1199

APPENDIX C
CONSENT FORM

Please return in enclosed envelope with questionnaires.

Youth Consent

I, _____, agree to participate in the
print name
Youth Bereavement Study being conducted by Hospice Care, Inc. I have read and I understand the procedure described. I understand that if I have any questions, or wish to talk further about my experience, I can speak with one of the Hospice counselors.

_____
signature & date

Parent/Guardian Consent

I, _____, agree for my child to
print name
participate in the Youth Bereavement Study being conducted by Hospice Care, Inc. I have read and I understand the procedure described.

_____
signature & date

APPENDIX D
YOUTH BEREAVEMENT QUESTIONNAIRE

Instructions

Please sign and have your parent sign the consent form.

Complete the Edwards Personal Preference Schedule.

You will find a booklet with the questions and a blue answer sheet on which to record your answers.

Use a #2 pencil to mark the answer sheet.

Please fill in the name at the top of the questionnaire. Your answer sheet will then be coded and your response will be kept confidential. Also indicate your age and sex.

Read the directions on the front of the booklet.

Work as rapidly as possible.

Some of the questions may be difficult to answer, but please give a response for each one.

After completing the questionnaire, check your answer sheet to make sure you have answered every question.

Complete the Youth Bereavement Questionnaire.

Record your answers on the questionnaire itself.

Please return the Edwards Personal Preference Schedule, the Youth Bereavement Questionnaire, and the consent form in the stamped, addressed envelope as soon as possible.

YOUTH BEREAVEMENT QUESTIONNAIRE

1. Name _____

2. Age _____; Date of Birth _____

3. Sex _____ M; _____F

4. Grade _____6;_____7;_____8;_____9;_____10;_____11;_____12

5. Race _____White; _____Black; Other, please specify _____

6. Who died? ____father, ____mother, ____stepfather,
_____ stepmother; If stepparent, for how long? _____

7. How old were you when your parent died? _____

8. How long has it been since your parent died?
0-2 months _____; 2-6 months _____; 6-12 months _____;
12-18 months ____; 18-24 months ____; 2 or more years ___

9. Grade point average _____

10. Religion _____Catholic; _____Protestant; _____Jewish;
_____None; Other, please specify _____

11. How long did you know your parent was dying before he/she died? Less than one week _____; 1-4 weeks _____ ;
1-6 months _____;6-12 months ____;More than 12 months ___;

12. How long was your parent ill before he or she died?
Less than one week _____; 1-4 weeks _____; 1-6 months __ ;
6-12 months _____; More than 12 months _____

13. Was there a funeral for your parent? _____Yes; _____No

14. If yes, did you attend the funeral? _____Yes; ____No

15. If you did not attend the funeral, do you wish you had attended? _____Yes; _____No

16. How old was your parent when he or she died? _____

17. Have you received counseling or attended a group in which you discussed your feelings about the death? ___Yes; ___No

18. Were your parents married to each other at the time of your parent's death? _____Yes _____; No

19. If not, were they _____Separated; _____Divorced

20. If your parents were not living together at the time of your parent's death, who were you living with?
_____ your mother; _____ your father
Other, please specify _____

21. If you did not live with the parent who died, how often did you see him or her? _____

22. Since the death of your parent, is your living parent
_____dating; _____not dating; _____engaged;
_____remarried

23. Do you live in the same home as you did before your parent's death? _____Yes; _____No

24. Are you _____the oldest child; _____a middle child;
_____the youngest child; _____an only child

25. Before the death of your parent, had you ever had anyone close to you die? _____Yes; _____No

26. Have you had one or more grandparents die? ____Yes;_____No

27. Have you had a brother or sister die? _____Yes; _____No

28. Have you had a friend die? _____Yes; _____No

29. Before the death of your parent, did your other parent work? _____Yes; _____No

30. If not, has parent begun to work? ____Yes; ____ No

To the right of the following statements, give the number which best reflects your thoughts or feelings:

1--Not at all

2--A little or Somewhat

3--Very much

4--Always or Extremely

31. Before my parent died, we had a good relationship. _____
32. My relationship with my living parent is good. _____
33. I am closer to my living parent now than I was before the death occurred. _____
34. My relationship with my brothers and sisters is good. ___
35. My living parent was supportive and helpful to me after my parent died. _____
36. My brothers and sisters were supportive and helpful to me after my parent died. _____
37. My friends were supportive and helpful to me after my parent died. _____
38. My teachers were supportive and helpful to me after my parent died. _____
39. I believe my living parent got more sympathy from others after my parent died than I received. _____
40. Before my parent's death, he or she and I talked about him/her dying. _____
41. My family talked openly about the fact that my parent was going to die. _____

1--Not at all; 2--A little or Somewhat;

3--Very much; 4--Always or Extremely

42. My family has talked openly about our feelings since my parent died. _____

43. My family is closer now than before the death. _____

44. I have to help more at home than I did before my parent died. _____

45. I have more responsibilities now than before my parent died. _____

46. I have more freedom now than before my parent died. _____

47. In my family, it is alright to talk about our feelings (for example, sadness, anger, guilt, etc.). _____

48. In my family, we participate in recreational activities together. _____

49. I felt relieved when my parent died. _____

50. I believe my parent could have prevented his or her death (for example, by not smoking, drinking, etc.). _____

51. My family is well adjusted and has few problems. _____

52. We have had financial problems since my parent died. _____

53. My religious beliefs helped me deal with the death of my parent. _____

54. I have had difficulty adjusting to my parent's death. ___

55. My living parent has had difficulty adjusting to my parent's death. _____

56. My brothers and sisters have had difficulty adjusting to my parent's death. _____

1--Not at all 2--A little or Somewhat

3--Very much 4--Always or Extremely

57. Having a parent die has made me a stronger person. _____

58. Having a parent die showed me who my friends really are. _____

59. Having a parent die caused me to evaluate my values or change things I was doing in my life. _____

60. I get upset whenever I think of my parent who died. _____

The following are common reactions to problems and stress. For each, indicate on the 1-4 scale used before if you had the reaction in the first month after the death, and if you are currently having this reaction.

1--Not at all
2--A little or Somewhat
3--Very Much
4--Always or Extremely

	1st Month	Now
61. Headaches	____	____
62. Tense muscles	____	____
63. Upset stomach or nausea	____	____
64. Loss of appetite	____	____
65. Eating too much	____	____
66. Problems sleeping	____	____
67. Nightmares	____	____
68. Weakness or lack of energy	____	____
69. Depressed/Sad	____	____
70. Angry	____	____
71. Guilty	____	____
72. Afraid/Scared	____	____
73. Shocked/Numb	____	____
74. Lonely	____	____
75. Suicidal/Want to die	____	____
76. Nervous/Anxious	____	____
77. Take drugs or alcohol	____	____
78. Problems with schoolwork	____	____
79. Want to be alone	____	____

1--Not at all 2--A little or Somewhat

3--Very much 4--Always or Extremely

	1st Month	Now
80. Moody/Irritable	____	____
81. Crying	____	____
82. Problems concentrating	____	____
83. Want to keep busy	____	____
84. In trouble with parent or at school	____	____
85. Think about the parent who died	____	____
86. Confused	____	____
87. Helpless	____	____
88. Think about death	____	____

Would you like to be contacted by a Hospice counselor?

_____ Yes _____ No

If yes, what is your phone number? _____

Comments:

APPENDIX E

ANOVA SUMMARY TABLE
RELATIONSHIP OF AGE AND SEX TO EPPS SCALES, ADJUSTMENT 1ST MONTH, PRESENT ADJUSTMENT, CHANGE IN ADJUSTMENT, AND PERCEIVED ADJUSTMENT (F VALUES)

Source	SS	df	F	p
Achievement				
Age	2.846	1	0.21	0.6469
Sex	3.930	1	0.30	0.5907
Age X Sex	2.981	1	0.22	0.6393
Error	344.610	26		
Deference				
Age	22.996	1	1.95	0.1747
Sex	30.010	1	2.54	0.1230
Age X Sex	2.576	1	0.22	0.6444
Error	307.059	26		
Order				
Age	54.154	1	3.06	0.0921
Sex	117.893	1	6.66	0.0159
Age X Sex	13.952	1	0.79	0.3828
Error	460.210	26		
Exhibition				
Age	21.846	1	2.11	0.1579
Sex	10.645	1	1.03	0.3194
Age X Sex	8.804	1	0.85	0.3644
Error	268.610	26		
Autonomy				
Age	9.099	1	0.59	0.4504
Sex	24.208	1	1.56	0.2225
Age X Sex	36.040	1	2.33	0.1393
Error	402.956	26		
Affiliation				
Age	1.741	1	0.14	0.7080
Sex	60.923	1	5.02	0.0339
Age X Sex	14.447	1	1.19	0.2854
Error	315.774	26		
Intraception				
Age	36.673	1	3.19	0.0855
Sex	106.561	1	9.28	0.0053
Age X Sex	22.808	1	1.99	0.1705
Error	298.474	26		

Source	SS	df	F	p
Succorance				
Age	6.571	1	0.53	0.4731
Sex	0.353	1	0.03	0.8673
Age X Sex	8.941	1	0.72	0.4035
Error	322.341	26		
Dominance				
Age	0.377	1	0.03	0.8583
Sex	8.024	1	0.69	0.4129
Age X Sex	16.646	1	1.44	0.2416
Error	301.326	26		
Abasement				
Age	140.869	1	14.26	0.0008
Sex	16.726	1	1.69	0.2045
Age X Sex	11.121	1	1.13	0.2984
Error	256.764	26		
Nurturance				
Age	26.252	1	1.50	0.2313
Sex	50.218	1	2.87	0.1020
Age X Sex	0.185	1	0.01	0.9189
Error	454.341	26		
Change				
Age	4.750	1	0.24	0.6284
Sex	180.750	1	9.13	0.0056
Age X Sex	1.523	1	0.08	0.7837
Error	514.841	26		
Endurance				
Age	8.650	1	0.38	0.5444
Sex	127.786	1	5.57	0.0260
Age X Sex	1.523	1	0.07	0.7986
Error	596.174	26		
Heterosexuality				
Age	56.695	1	2.10	0.1592
Sex	46.342	1	1.72	0.2015
Age X Sex	90.981	1	3.37	0.0778
Error	701.610	26		
Aggression				
Age	7.262	1	0.38	0.5415
Sex	0.153	1	0.01	0.9292
Age X Sex	0.085	1	0.00	0.9470
Error	493.264	26		
Consistency				
Age	24.891	1	4.05	0.0545
Sex	10.774	1	1.75	0.1968
Age X Sex	0.521	1	0.08	0.7730
Error	159.641	26		

Source	SS	df	F	p
1st Month Adjustment				
Age	320.872	1	1.50	0.2322
Sex	1295.683	1	6.05	0.0211
Age X Sex	549.016	1	2.57	0.1218
Error	5349.700	25		
Present Adjustment				
Age	6.902	1	0.04	0.8471
Sex	624.378	1	3.44	0.0760
Age X Sex	4.864	1	0.03	0.8714
Error	4357.742	24		
Change in Adjustment				
Age	265.953	1	1.57	0.2222
Sex	142.096	1	0.84	0.3687
Age X Sex	493.487	1	2.91	0.1007
Error	4063.503	24		
Perceived Adjustment				
Age	0.016	1	0.03	0.8727
Sex	0.663	1	1.12	0.3006
Age X Sex	0.957	1	1.61	0.2156
Error	15.441	26		

APPENDIX F

ANOVA SUMMARY TABLE
RELATIONSHIP OF SEX AND RELATIONSHIP OF DECEASED TO EPPS SCALES, 1ST MONTH ADJUSTMENT, PRESENT ADJUSTMENT, CHANGE IN ADJUSTMENT, AND PERCEIVED ADJUSTMENT

Source	SS	df	F	p
Achievement				
Deceased	3.803	1	0.30	0.5889
Sex	0.625	1	0.05	0.8262
Deceased X Sex	12.469	1	0.98	0.3308
Error	330.125	26		
Deference				
Deceased	16.900	1	1.53	0.2266
Sex	16.900	1	1.53	0.2266
Deceased X Sex	36.100	1	3.28	0.0819
Error	286.500	26		
Order				
Deceased	6.136	1	0.32	0.5794
Sex	112.225	1	5.76	0.0238
Deceased X Sex	7.803	1	0.40	0.5323
Error	506.375	26		
Exhibition				
Deceased	6.136	1	0.70	0.4102
Sex	1.736	1	0.20	0.6598
Deceased X Sex	73.803	1	8.43	0.0074
Error	227.708	26		
Autonomy				
Deceased	15.211	1	1.06	0.3124
Sex	0.278	1	0.02	0.8903
Deceased X Sex	49.878	1	3.48	0.0734
Error	372.583	26		
Affiliation				
Deceased	0.400	1	0.03	0.8576
Sex	71.111	1	5.84	0.0230
Deceased X Sex	14.400	1	1.18	0.2869
Error	316.750	26		
Intraception				
Deceased	73.803	1	7.25	0.0122
Sex	186.336	1	18.30	0.0002
Deceased X Sex	10.336	1	1.02	0.3229
Error	264.708	26		

Source	SS	df	F	p
Succorance				
Deceased	0.900	1	0.08	0.7844
Sex	5.878	1	0.50	0.4862
Deceased X Sex	28.900	1	2.45	0.1294
Error	306.250	26		
Dominance				
Deceased	0.711	1	0.07	0.7994
Sex	0.000	1	0.00	1.0000
Deceased X Sex	37.378	1	3.46	0.0740
Error	280.500	26		
Abasement				
Deceased	3.803	1	0.26	0.6135
Sex	1.225	1	0.08	0.7740
Deceased X Sex	29.469	1	2.02	0.1666
Error	378.375	26		
Nurturance				
Deceased	0.100	1	0.01	0.9377
Sex	117.878	1	7.35	0.0117
Deceased X Sex	62.500	1	3.89	0.0592
Error	417.250	26		
Change				
Deceased	2.025	1	0.11	0.7458
Sex	140.625	1	7.45	0.0112
Deceased X Sex	24.025	1	1.27	0.2695
Error	490.625	26		
Endurance				
Deceased	9.344	1	0.43	0.5179
Sex	108.900	1	5.01	0.0340
Deceased X Sex	24.544	1	1.13	0.2979
Error	565.500	26		
Heterosexuality				
Deceased	12.100	1	0.42	0.5230
Sex	104.544	1	3.62	0.0681
Deceased X Sex	84.100	1	2.91	0.0997
Error	750.250	26		
Aggression				
Deceased	3.403	1	0.22	0.6435
Sex	15.625	1	1.01	0.3248
Deceased X Sex	83.136	1	5.36	0.0288
Error	403.375	26		
Consistency				
Deceased	25.069	1	4.23	0.0500
Sex	25.069	1	4.23	0.5000
Deceased X Sex	2.336	1	0.39	0.5357
Error	154.208	26		

Source	SS	df	F	p
1st Month Adjustment				
Deceased	8.628	1	0.04	0.8522
Sex	1433.185	1	5.89	0.0228
Deceased X Sex	204.983	1	0.84	0.3677
Error	6087.967	25		
Present Adjustment				
Deceased	2.510	1	0.01	0.9074
Sex	546.039	1	3.00	0.0959
Deceased X Sex	6.627	1	0.04	0.8502
Error	4361.667	24		
Change in Adjustment				
Deceased	3.176	1	0.02	0.9004
Sex	186.706	1	0.94	0.3416
Deceased X Sex	114.353	1	0.58	0.4551
Error	4760.250	24		
Perceived Adjustment				
Deceased	0.011	1	0.02	0.8885
Sex	0.011	1	0.02	0.8885
Deceased X Sex	1.878	1	3.39	0.0772
Error	14.417	26		

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Paul G. Schauble, Chairman
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Franz R. Epting
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Harry A. Grater, Jr.
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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